

Advanced Pain Management Center  
**Dr.Satish Sharma,MD**



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## **FMLA**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please read the following disclaimer: A **\$25.00 fee** will apply for EVERY packet needing to be filled out by the Provider, fee is to be paid prior to forms being filled out. **Allow 5-7 business days for turn around and completion time.** The office of Dr. Sharma is not responsible for submitting forms to employer as a courtesy, forms will be faxed once to the provided number patient lists. All hard copies will be in office ready for patient to pick up once completed.

Is this a \_\_\_\_\_ Continuous \_\_\_\_\_ Intermittent leave.

Is this a \_\_\_\_\_ renewal \_\_\_\_\_ 1<sup>st</sup> time receiving FMLA?

Please list the probable cause: What is the reason/issue you are requesting forms, for example back pain, neck pain.

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**\*For any further questions or concerns regarding FMLA please Email [FMLAAPMC@gmail.com](mailto:FMLAAPMC@gmail.com)  
Please be sure to specify the needs of your request and we will get back to you in a timely fashion.**