KAISER PERMANENTE®

☐ **Disability Form** ☐ **FMLA** ☐ **Recertification**

Release of Information Department
10220 SE Sunnyside Rd., Clackamas, OR 97015-9764
Phone: 503-571-5051 Fax: 503-571-2624
NW.ROI@kp.org Info.kp.org/Northwest/ROI

Tracking Number: _____ Claim Number: _____

Patient Information	TODAY'S DATE	DATE OF BIRTH (MM/DD/YY)	PATIENT HEALTH RECORD #
	PATIENT FULL NAME		CONTACT TELEPHONE #
	MAILING ADDRESS		

Family Member Request	YOUR NAME	CONTACT TELEPHONE #
	RELATIONSHIP TO PATIENT	

Patient's Condition	MEDICAL CONDITION	ESTIMATED DATE OF ONSET OF CONDITION OR INJURY (MM/DD/YY)
	NAME OF TREATING CLINICIAN/MD AUTHORIZING TIME LOSS	

Work Status History	EMPLOYER NAME	JOB TITLE/FUNCTION
	WORK SCHEDULE	DESCRIBE USUAL WORK ACTIVITY ☐ Mostly sitting ☐ Physical (walking, standing, lifting)

Leave Information

Continuous Leave: Start date (mm/dd/yy): _____ Through (mm/dd/yy): _____

Intermittent Leave: Start date (mm/dd/yy): _____ Through (mm/dd/yy): _____

# of episodes per month: _____ # of days per episode: _____ Duration: ☐ 3 months ☐ 6 months

In the last 3 months, how many work absences have been needed by the patient/family member for this condition? _____

☐ Modified duty (lift/stand/sit) Start date: _____ Through: _____

☐ Reduced daily work hours Start date: _____ Through: _____

Hours per day: _____ Days per week: _____ Other: _____

Delivery Method Authorization

☐ Email ☐ Fax ☐ Mail ☐ Pickup at ROI Recipient: _____

EMAIL, FAX NUMBER, OR POSTAL ADDRESS

Authorization for Release of Protected Health Information: I authorize Kaiser Permanente to release healthcare information necessary for FMLA or disability form completion to the recipient/entity named above. This authorization is valid for the duration of the claim but not to exceed one (1) year from the date signed. I understand that I can revoke this authorization at any time by giving a written request to Kaiser Permanente and that I have the right to receive a copy of this authorization.

☐ Check box if you intend to include drug/alcohol diagnosis, treatment or referral information, HIV/AIDS information, mental health information and genetic testing information.

PATIENT SIGNATURE AUTHORIZING RELEASE PLEASE PRINT & SIGN USING BLUE OR BLACK INK (No electronic signatures will be accepted)	DATE/TIME

Instructions and Definitions

Form Request for Family Medical Leave Act (FMLA) or Short-term or Long-term Disability

Patient Information	Please fill in ALL patient information.
Family Member Request	If you are completing this form to assist in the care of a family member, please include your name, your relationship to the patient (i.e. parent, spouse, child), and your telephone number along with the best time of day to call.
Patient's Condition	Please provide the medical condition related to this request and the date the condition or injury occurred for the first time. If the exact date cannot be remembered, give an estimated month and year. Also, provide the name of your treating clinician/doctor who will be signing your work loss request.
Work Status History	Please provide the name of your employer, job title and/or your major job function (what you do). Indicate your work schedule, i.e., number of hours per day and days per week, and whether your job is mostly sitting or more physical, with walking, standing, or lifting.
Leave Information	**Continuous FMLA** leave is defined as when an employee is absent for more than three consecutive business days and has been treated by a doctor. Please provide the start date and the through date. **Intermittent FMLA** leave is often taken when an employee needs time off work for condition flares or treatment of their condition. Please provide how many work absences per month you have taken in the LAST 3 MONTHS along with an estimate of how many you may need for this request. **Modified Work Duty** is defined as a change in the regular job duties of an employee because of injury or illness. These changes may include tasks or functions, work schedule, workload, work area, and equipment. The modified work program is only temporary, giving the injured or sick employee a period of time to regain normal condition. **Reduced Daily Work Hours** is defined as when an employee needs to reduce the number of hours worked per day or per week, often to care for a family member or to reduce effects of his or her own illness.
Delivery Method and Authorization	If completed form is to be sent to anyone other than the patient, the patient must authorize the release of the form, which contains protected health information, with a hand written signature. If the authorization is not signed, the completed form will be mailed to the patient.

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