PLEASE REVIEW DIRECTIONS ON THE OTHER SIDE OF THIS FORM. INCOMPLETE FORMS WILL DELAY PROCESSING TIME. PLEASE INFORM PATIENT FMLA FORM PROCESS WILL TAKE UP TO 15 CALENDAR DAYS.

KAISER PERMANENTE®

KP USE ONLY

KP Use Only: Your requested FMLA dates may not be approved exactly as requested. The FMLA Department follows federal guidelines when reviewing and approving all requests.

☐ Employee Complete all except #2 ☐ Complete ROI for caregiver request
☐ Family member/Caregiver complete all sections
☐ Executive Staff only

1	Patient Information **Must be filled out completely**	Date Submitted by patient:	Date of Birth (mm/dd/yy):	Patient Health Record #:
		Patient Full Name:		Contact Telephone #: Best Time to Call:

☐ Yes ☐ No - Is this form for the patient's employer? If yes, skip #2 and complete #3 thru 7 (if applicable)

2	Caregiver/Family Member **Leave blank if request is for patient time off**	Name of Caregiver/Family Member who will be providing the care:	Contact Telephone #: Best Time to Call:
		Relationship to Patient:	

3	Patient's Condition **Must be filled out completely**	Name of treating Clinician/MD Authorizing Time Loss:	Medical Condition:

Front Desk/Nursing Staff: *ROI form also needs to be completed by the patient if FMLA is for the* ***caregiver****.*

4	Work Status History **Must be filled out completely**	Employer Name (company that you work for):	Employee's Job Title:
			Job Functions:
			Work Schedule:

Which TYPE of FMLA? MUST complete either #5, #6, or #7 or any combination of the 3 (if applicable).

5	Intermittent Leave ***(2 treatment visits needed in the past 12 months to qualify: in-person, tele, video)***	**ESTIMATE THE NUMBER OF DAYS YOU MAY NEED FOR THIS REQUEST:** Total # of work absences per month _____ ☐ Not Applicable Start Date (mm/dd/yy): _____ Duration ☐ 3 months ☐ 6 months ****Please note that 6 months is the longest that intermittent FMLA will be approved for.***

6	Continuous Leave	Start Date: _____ Return to work date: _____ ☐ Not Applicable	Notes/Comments:

7	Other Leave		☐ Reduce Daily Work Hours Start Date: _____ ☐ Not Applicable Returning to regular work hours: _____ # hours per day: _____ # days per week: ____

DIRECTIONS — Is this request for treatment by a specialist/surgeon?
If **YES**, please have specialist/surgeon complete your form.
Please note that FMLA forms can take up to 15 calendar days to process.

1	Patient Information	Please fill in ALL patient information. A combination of two office visits, telephone and/or video visits for patient's chronic condition is required. Emails are not accepted as visits.
2	Family Member Request	If you are completing this form to assist in care of the patient and you are the caregiver, please include your name, your relationship to the patient (i.e., parent, spouse, child), your telephone number along with the best time of day to call. *The patient receiving the care will also need to complete a Release of Information Form (ROI) for the caregiver.
3	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.
4	Work Status History	Please provide the name of the company that the **patient** works for, a contact name (supervisor), and their telephone number. Also, include job title, job functions and work schedule.

Requesting which TYPE of FMLA?
MUST complete either #5, #6, or #7 or any combination of the 3 (if applicable)

5	Intermittent Leave	**Intermittent FMLA** leave is often taken when an employee needs time off work for condition flare ups 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. ***Please note that the authorizing Clinician/MD will only approve intermittent FMLA for up to 6 months. After 6 months, a new FMLA form must be submitted.****
6	Continuous Leave	**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 (end date).
7	Other Leave	**Reduced Daily Work Hours** is defined as when an employee needs to reduce the amount of hours they work per day or per week, often to care for a family member or to reduce effects of their own illness.
	Additional Comments	Write any additional comments that will help us understand your request.