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 2 weeks

1	Patient Information	Please fill in ALL patient information.
2	Family Member Request	If you are completing this form to assist in care of a family member, 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 member receiving the care will also need to complete a Release of Information Form (ROI) or have a VROI on file.
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 you work 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 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. ***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.
7	Other Leave	**Modified work duty** is defined as the 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 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.

PLEASE REVIEW DIRECTIONS ON THE FRONT OF THIS FORM. INCOMPLETE FORMS WILL DELAY PROCESSING TIME
PLEASE INFORM PATIENT FMLA FORM PROCESS WILL TAKE UP TO 2 WEEKS..

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.

☐ Patient Complete all except #2 ☐ ROI Completed (if applicable) ☐ Clerk Name: _____
☐ Family member complete all sections ☐ Nurse to do VROI (if applicable) ☐ Executive Staff only
☐ Is this a request for treatment by a specialist/surgeon? If yes, please have Specialist/Surgeon complete this form.

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?

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

☐ Yes ☐ No – Is this form for the family member or caregiver's employer?

3	Patient's Condition **Must be filled out completely**	Estimated Date of onset of condition or injury (mm/dd/yy):	Medical Condition:
		Name of treating Clinician/MD Authorizing Time Loss:	

Front Desk Staff: *ROI form also needs to be completed by the member who is receiving the care*

4	Work Status History of the Person Needing Time Off from Work	Employer Name (company that you work for):	Employee's Job Title:
		Employer Contact Name (supervisor):	Job Functions:
		Employer Telephone #:	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 THE LAST 3 MONTHS:** How many work absences have been needed by the patient/family member for this condition? Total # of Days Per Month _____
		ESTIMATE OF THE NUMBER OF DAYS YOU MAY NEED FOR THIS REQUEST: Total # of work absences per month _____ ☐ Not Applicable Start Date (mm/dd/yy): _____ ***Please note that 6 months is the longest that intermittent FMLA will be approved for.*** Duration ☐ 3 months ☐ 6 months

6	Continuous Leave	Start Date: _____ Through: _____ ☐ Not Applicable	*OB ONLY* Due Date: _____ Last day of work:_____ Was your last day worked more than 2 weeks before your due date? Y/N If yes, please state reason in comment box below. Date of delivery: _____ Date admitted to hospital: _____ Date discharged: _____

7	Other Leave	☐ Modified Duty (lift, stand, sit) Start Date: _____ Through: _____ ☐ Not Applicable	☐ Reduce Daily Work Hours Start Date: _____ ☐ Not Applicable Through: _____ # hours per day: _____ # days per week: ____

Additional Comments/Type of care needed?	