

Your information

Name: _____ Kaiser Permanente number: _____
Date of birth: _____ Today's date: _____

Delivery method/recipient

- Secure member account on kp.org/wa
- In person pick up Self 3rd party: _____
- Fax Attention: _____ Fax number: _____
- Mail Self 3rd party: Mail to: _____
Address: _____
City: _____ State: _____ ZIP: _____

About your condition

Your Kaiser Permanente clinician's name: _____
Where are you seen for this condition? _____
Provide a brief description of the condition, injury or diagnosis: _____
Approximate start date of condition: _____ Estimation of conditions duration: _____

Request type

Which documents are you requesting? FMLA WA PFML
Have you been seen for this condition at least twice in the last year? Yes No (schedule an office visit)

Work status history

Employer name: _____ Job title: _____
Regular work schedule: _____
What are your job functions?

What job functions are you unable to perform due to your condition?

Type of leave

- In patient care** (hospitalization, hospice, or residential care)
Overnight stays on: _____ (m/d/yy)
- Incapacity plus treatment** The patient was incapacitated for more than three consecutive, full calendar days
Start Date: _____ End Date: _____
When were you seen for treatments? _____
 Has continuing treatment Doesn't have continuing treatment
- Pregnancy** Expected delivery date: _____
- Chronic conditions (e.g. asthma, migraine headaches)** Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
- Permanent or long term conditions: (e.g. Alzheimer's, terminal stages of cancer)** Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided)
- Conditions requiring multiple treatments: (e.g., chemotherapy treatments, restorative surgery)** Due to the condition, it is medically necessary for the patient to receive multiple treatments.
- None of the above** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed.

Leave information

- Planned treatment Dates: _____
 Referral information Start date: _____ End date: _____

Referred treatment: _____

Estimated duration of treatment: _____

Estimated leave

- | | | |
|--|---|---|
| <input type="checkbox"/> Continuous incapacity
(A continuous period you're unable to work)

Start Date: _____

End Date: _____ | <input type="checkbox"/> Intermittent incapacity
(Condition causes occasional flare-ups)

Estimate frequency and duration of flare-ups over the next 6 months:

Frequency: _____ episode(s) per
<input type="checkbox"/> day
<input type="checkbox"/> week
<input type="checkbox"/> month

Lasting: _____
<input type="checkbox"/> hour(s) per episode
<input type="checkbox"/> day(s) per episode | <input type="checkbox"/> Reduced schedule
Reduced work hours:

Start Date: _____

End Date: _____

_____ # hour(s) per day
_____ # day(s) per week |
|--|---|---|

Please note Certified time off is based on medical need and may be different than the time requested.

Forms Processing Acknowledgment

- This acknowledgment must be signed by the patient, parent, legal guardian, or person with legal power of attorney prior to the completed form being picked up, mailed, or faxed.
- Kaiser Permanente Washington requires up to **fifteen (15) calendar days** for processing all forms.
- This form complies with 45 CFR 164.524 (c) 3 (also known as HITECH Act)

I have read, understand, and agree to the above forms processing acknowledgment statements.

Signature of patient, parent, legal guardian, or person with legal power of attorney

Date