Federal Medical Leave Act & WA Paid Family and Medical Leave
Employee intake form

KAISER PERMANENTE

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: ______________________
____

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.

Continue to the back side

Federal Medical Leave Act & WA Paid Family and Medical Leave
Employee intake form

KAISER PERMANENTE®

Leave information

☐ Planned treatment Dates: ______________________
☐ Referral information Start date: ______________ End date: ______________

Referred treatment: ______________________

Estimated duration of treatment: ______________________

Estimated leave

☐ **Continuous incapacity**
(A continuous period you're unable to work)

Start Date: ______________

End Date: ______________

☐ **Intermittent incapacity**
(Condition causes occasional flare-ups)

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

Frequency: ________ episode(s) per

- ☐ day
- ☐ week
- ☐ month

Lasting: ________

- ☐ hour(s) per episode
- ☐ day(s) per episode

☐ **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