

1. Patient Information		
Today's date:	Patient date of birth:	Kaiser Permanente ID number:
Patient's name:		Patient phone #:
Mailing address:		
2. Method of Form Delivery		
Has the patient signed an Authorization to Disclose Health Care Information form? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, see a Patient Access Representative)</i> <input type="checkbox"/> In-person pick-up <i>(Specify name if someone other than patient is authorized to pick up):</i> _____ <input type="checkbox"/> By fax <i>(Recipient name and fax #):</i> _____ <input type="checkbox"/> By mail <input type="checkbox"/> By MyChart/online <i>(FMLA requests only)</i>		
3. About the Patient's Condition		
Name of Kaiser Permanente clinician seeing the patient: _____		
Brief description of the condition, injury or diagnosis: _____		
Was the patient in the hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what dates? _____		
4. Request Type		
Is this an FMLA request? <input type="checkbox"/> Yes <i>If yes, continue below</i> <input type="checkbox"/> No <i>If no, specify request type:</i> _____ Is this a WA PFML request? <input type="checkbox"/> Yes <i>If yes, continue below</i> <input type="checkbox"/> No <i>If no, specify request type:</i> _____ Has the patient been seen for this condition at least 2 times? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If no, schedule office visit)</i>		
5. Work Status History (FMLA and WA PFML requests <u>only</u>)		
Employer name:	Employer contact:	
Patient's job title:	Regular work schedule:	
Describe patient's job functions:		
6. Estimated Leave Time (FMLA and WA PFML requests <u>only</u>)		
<input type="checkbox"/> Continuous Leave: Patient is unable to work for a single continuous period of time Estimate period of inability: Start date _____ End date _____	<input type="checkbox"/> Follow-Up Treatment Leave: Patient needs scheduled follow-up care and/or reduced work hours Estimate follow-up care and/or reduced work hours: # hours per day _____ # days per week _____ Start date _____ End date _____	<input type="checkbox"/> Episodic Leave: Condition causes occasional flare-ups Estimate frequency and duration of flare-ups over the next 6 months: Frequency: _____ times per _____ week(s) _____ per _____ month(s) Duration: _____ hours or _____ day(s) per episode
Please note: Certified time off will be 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 ten (10) days for processing all forms.

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

BUSINESS OPERATIONS USE ONLY

Clinician to complete form: _____

Special instructions to clinician: _____

Special instructions to Business Office staff: _____

Request received by: _____

If the form is being mailed/faxed to a third party, has
an Authorization to Disclose (Release) Health Care
Information form been completed? Yes No

If the Authorization to Disclose (Release) Health Care
Information form is not required, has this Intake
form been signed by the patient? Yes No