Disability/FMLA Form Request

Scanned/Faxed by:____________ **Today's Date** _________________

4100 N Mulberry Dr. Suite 300
Kansas City, MO 64116
816-437-9134

We are pleased to assist you in completing your Disability and FMLA forms. Be advised there will be a 10 business day processing time frame, as well as a processing fee based on the type of form.

We understand you may have an urgent deadline for your paperwork and will do our best to accommodate; however all paperwork will be processed in the order that we receive it without exception. If you would like a copy of the form for yourself, please contact Klamath Orthopedic Clinic directly.

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your information. By completing the form below, you are authorizing disclosure of your private health information.

***Indicates Required Field**

***Patient's Name** *(First, Middle Initial, Last)*____

***Date of Birth** _________________________ ***Preferred Daytime Phone Number** __________________________________

OK to Leave a Detailed Phone Message? ☐ **Yes** ☐ **No** ***E-Mail Address** __________________________________

**Email address will be used to provide status updates*

☐ **Disability forms** ($25) ☐ **FMLA Forms** ($25)

Date of Symptoms Onset: ___________________________ **First Day Unable To Work**:__________________________

Length of expected leave:___________________

***Name of company or employer to receive form:**

Complete additional copy of this form for each form requested.

Name:____

Address:____

____

Fax:____

*****Attach this form to the document to be completed for disability determination**

I authorize Klamath Orthopedic Clinic to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition, including: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.

I also acknowledge I am responsible to pay the form completion fee prior to form completion.

Signature: ____ Last 4 digits of your SS# ___________

Write your full name

☐ I electronically sign this document and agree to the terms and conditions and that the information is accurate. Further I verify my identity through this electronic signature.

Disability/FMLA Form Request

DOCTOR: ______________________

BODY PART: ____________________

SURGERY DATE: _________________

ARE YOU REQUESTING TO GO BACK TO WORK?

REGULAR DUTY ____ STATUS FROM (DATE) ______________________________

MODIFIED DUTY ___ STATUS FROM (DATE) ____________TO _______________

TOTAL WORK HOURS: ______ PER DAY

NO WORK AT ALL __ FROM DATE _______________ TO _______________

WHAT SORT OF JOB DO YOU DO ____

____

____

ON A TYPICAL SHIFT, WHAT IS INVOLVED?

SIT __________HRS

STAND _______HRS

WALK ________HRS

PUSHING _____ WEIGHT (frequent) _____ WEIGHT (occasional)

PULLING ______WEIGHT (frequent) _____ WEIGHT (occasional)

LIFTING _______WEIGHT (frequent) _____ WEIGHT (occasional)