

Disability/FMLA Form Request



Scanned/Faxed by: _____	Today's Date _____	1750 Founders Parkway, Suite 130 Alpharetta, Georgia 30009 816-437-9134
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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: _____

Write your full name

Last 4 digits of your SS# _____

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)