



Disability/FMLA Form Request



Scanned/Faxed by: _____ MRN# _____	Today's Date _____	4100 N. Mulberry Dr, St 300 Kansas City, MO 64116 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 KC Pain Centers directly at 816-763-1559.

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 (\$50)**

**FMLA Forms (\$50)**

**Date of Injury/Pain 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 KC Pain Centers 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.

**Signed Release on File**

**I approve this form completion**

\_\_\_\_\_  
**Provider/Designee Signature**

**(Please Complete page 2)**

Disability/FMLA Form Request

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **MRN:** \_\_\_\_\_  
 (First, Middle Initial, Last) (for office use only)

**Job Title:** \_\_\_\_\_ **Work Schedule:** \_\_\_\_\_

**Type of Leave:** (check all that apply) \_\_\_ New Request \_\_\_ Extension/Recertification \_\_\_ On the Job Injury

**Requested FMLA: (check all that apply)**

\_\_\_ Taken periodically over an extended period of time. Reduced Work Schedule

\_\_\_ Taken on consecutive days; employee is able to work some of his/her work schedule each day.

**Physical Demands** (in a typical work day, indicate the frequency of a task by placing a mark in the appropriate box):

PHYSICAL DEMANDS	Percentage of Time Designation			
	Rarely <1%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Carrying objects < 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing (step stool)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting <10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-30 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30+ pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing (estimated weight): ___ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling (estimated weight): ___ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repetitive motion with the wrists, hands and fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs (ascend/descend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>