Disability/FMLA Form Request

LEE'S SUMMIT PHYSICIANS GROUP

Forms may be faxed to:
816-525-2697

DataFile Technologies

Scanned/Faxed by: _____ **Today's Date:** _____

4100 N. Mulberry Dr, Ste 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 processing fee for completion of the form(s).

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. Please allow 7-10 business days for form completion. If you wish to retain a copy of the form for your records, you may do so by requesting it through the clinic.

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your 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** _____

□ **Disability forms** ($40) □ **FMLA Forms** ($40) □ Expedite **the Form** (+$10)

Date Injury/Illness Began: _____ **First Day Unable To Work**:_____
Length of expected leave/return date to work:_____
If for FMLA, is this for continuous leave, intermittent leave, or both?: _____
What is the diagnosis that the form should be completed for?: _____
Is surgery being performed? When & what type?: _____

Complete additional copy of this form for each form requested.

Where Does the Completed Form Need to Go?
Name of Company/Location: _____
Address (If needing form mailed): _____
City, State, Zip Code: _____ _____
Fax Number/E-Mail: _____

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

I authorize Lee's Summit Physicians Group 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# _____

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