



FAX THIS FORM TO: (913) 492-9025

**FAMILY MEDICAL LEAVE ACT SHORT TERM DISABILITY
RETURN TO WORK COVER SHEET**

KANSAS CITY WOMEN'S CLINIC

KCWC: A tradition of excellence since 1953

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OVERLAND PARK, KANSAS 66215-2309
(913) 894-8500

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(913) 696-1900

ADMINISTRATIVE FAX: (913) 492-2874
MEDICAL RECORDS FAX: (913) 492-9025
WWW.KANSASCITYWOMENSCLINIC.COM

Name: _____
(Please print)

DOB: _____

The fee for completing each form supplied by your employer is \$20.00 (per form) payable to Kansas City Women's Clinic, and must be **PREPAID**. Forms may be dropped off at either one of our Overland Park offices or faxed to (913) 492-9025. Expect a minimum of five to seven business days for completion.

We will need the following information:

1. First date of disability (or due date)

2. Reason for taking early leave (if applicable)

3. Where to send completed forms:

- I will pick up at the reception desk.
 - Mail to my home
 - Mail to my employer or disability company
- Complete address: _____

- Fax to my employer or disability company
- Fax number: _____

Attention: _____

Please note that physician authorized leave time is for medical reasons only.

I authorize Kansas City Women's Clinic to furnish this information to my employer and/or disability company.

Signature _____ Date _____

A/C # _____ Amount Paid \$ _____ Check # _____

Cash _____

MC/VISA _____

*Number of faxed pages including this Cover Sheet _____