



Short Term Disability/ Family and Medical Leave Request Form

Human Resources - Benefits

SEE NEXT PAGE FOR INSTRUCTIONS

A. EMPLOYEE INFORMATION

Employee Name _____ PENN ID _____
(Last) (First) (Middle Initial) (Middle 8 digits on Penn Card)

Do you have prior service with the University of Pennsylvania? Yes No Original Hire Date: _____

Home Address _____

City, State and Zip+4 _____ Home Phone _____

Status Full-Time Part-Time Temp Hours Worked Per Week _____

Business Administrator _____ BA Location _____ BA Phone _____

B. TYPE OF LEAVE

If this request for leave is due to the employee's own serious health condition or the serious health condition of a family member, a completed Certification of Health Care Provider Form must be forwarded to the FMLA Administrator by the employee or the attending physician/practitioner within twenty (20) days of this request.

- FMLA (Family/Medical Leave)** I am requesting FMLA Leave of Absence for one or more of the following reason(s):
 - Birth of my child and in order to care for him or her
 - Care for my eligible family member who has a serious health condition
 - Placement of a child with me for adoption or foster care
 - Spouse/Same-Sex Domestic Partner
 - Child: Age ___
 - Parent
 - Military Leave
 - Qualifying Exigency
 - Service Member Illness/Injury
 - Serious health condition that makes me unable to work
- Other Medical** (for the employee's own serious health condition and when FMLA is exhausted or employee is not eligible)

C. DURATION

Date Leave to Begin: _____ Expected Return to Work Date: _____

- Consecutive time off
- Intermittent Leave or Reduced Leave Schedule (Specify schedule on a separate sheet of paper)

This request is also my written intent to return to work on the return to work date stated above. I understand that I will need a 'Fitness-for-Duty' note from my physician if this leave of absence is for my own serious health condition. I understand that I am required to keep my supervisor informed and up-to-date of my situation throughout the leave periodically and as agreed upon by my supervisor and myself. If I fail to return by the agreed date without an approved extension and/or re-certification of a serious health condition, I am aware that I may be deemed to have abandoned my job.

D. TO BE COMPLETED BY DEPARTMENT

The FMLA/STD Policy has been reviewed and given to the employee.
The employee had the following balances as of the last date worked.

- _____ Sick Days
- _____ PTO (Vacation) Days
- _____ Short Term Disability Days
- _____ Other

Supervisor Signature (Date supervisor reviewed this form with employee) Employee Signature

Supervisor - Print Name

RETURN COMPLETED FORM TO:

University of Pennsylvania, Human Resources, Benefits, 3401 Walnut Street, Suite 527A, Philadelphia, PA 19104-6228

PROTOCOL

For Short Term Disability/ Family and Medical Leaves of Absence

EMPLOYEE INFORMATION:

1. Complete Sections A, B and C of Request for Leave of Absence Form. Return completed Request for Leave of Absence Form to manager/supervisor.
2. Review with manager/supervisor the use of accrued sick, vacation and/or personal time.
3. For leaves of absence due to the employee's own serious health condition or the serious health condition of a family member, the health care provider or the health care provider of the family member must complete the appropriate Certification of Health Care Provider Form (Employee's Serious Health Condition or Family Member's Serious Health Condition). Both Certification of Health Care Provider forms can be obtained from your manager, your local Human Resources office, the Human Resources – Benefits Office, or the Human Resources website (www.hr.upenn.edu/forms).
4. The employee or employee's physician will forward the completed Certification of Health Care Provider Form to the Human Resources Benefits office at 3401 Walnut Street, Suite 527A, Philadelphia, PA 19104-6228. The date of the employee's anticipated return to work must be completed by the physician/practitioner on the Certification of Health Care Provider Form. The first day of leave is the first day you are absent from work whether paid or unpaid as certified by your Health Care Provider.

SUPERVISOR:

1. When the Request for FMLA/STD is received, verify the employee's service and time records to determine his/her eligibility for the requested leave. For leave under the Family Medical Leave Act, an employee must have been employed by the University for twelve (12) months and have worked 1,250 hours during the 12 month period immediately preceding the start of the leave. If an employee has used 12 weeks of leave under FMLA in the past 12 months, the leave will be designated as Short-Term Disability leave if the employee has available short-term disability days and the absence is 10 days or longer
2. Complete Section D of the form and review with the employee.
3. Forward the completed Short Term Disability/Family and Medical Leave Request Form to the Human Resources/Benefits Office at 3401 Walnut Street, Suite 527A, Philadelphia, PA 19104-6228.