Instructions:

1. Enter your leave request in Workday:
   - Go to Workday “Time Off and Leave Application”
   - Click on “Request Leave of Absence”
   - Enter the “First Day of Leave” and the “Estimated Last Day of Leave”
   - Click on Leave Type “FMLA” and scroll through to choose the type of FMLA leave being requested

2. After submitting your request, look for a notification email from Workday. Follow the link and download the appropriate packet for your type of leave.

3. If the leave is for your own serious health condition, have your physician complete the Certification of Health Care Provider form, and the Attending Physician Statement.
   - If requesting leave for pregnancy, or on an intermittent basis, the Attending Physician Statement isn’t required.
   - If your leave is for the care of a family member, the Certification of Health Care Provider form must be completed by that family member’s physician.
   - For Paid Parental Leaves, a medical certification is not required. Instead, please submit verification of birth.

4. Return all required documentation to the Leave Administrators via fax to (215) 405-2929 or email to FMLA@hr.upenn.edu.

5. Once your leave has been processed, you will be notified by email and postal mail.
Frequently Asked Questions:

1. **How do I submit my completed paperwork?**
   All leave paperwork must be faxed to (215) 405-2929 or emailed to FMLA@hr.upenn.edu. No paperwork will be accepted in person or by mail.

2. **How do I check the status of my leave?**
   To check the status of your leave, please send an email to FMLA@hr.upenn.edu.

3. **How long will it take to process my leave?**
   Processing times vary based upon current volume, but please be advised that we aim to process all leaves as quickly as possible.

4. **Who are considered eligible family members under FMLA?**
   An employee’s spouse, parent or child (under the age of 18) are considered eligible family members under the FMLA. Children age 18 and over may be eligible if incapable of self-care because of a mental or physical disability.

5. **What documentation is required to take FMLA for adoption?**
   Court issued placement documentation, or an adoption decree is required.

6. **Am I required to submit a delivery note after the birth of my child?**
   Yes. A verification of birth document must be submitted after the birth of a child. Failure to submit the note could affect STD and/or PPL payments.

7. **Am I eligible for Short Term Disability?**
   Full time employees taking leave for their own serious health condition or pregnancy may be eligible for STD. An Attending Physician Statement must be completed.

8. **Does STD run concurrently with FMLA?**
   Yes, if both leaves are approved for the same periods of time.

9. **Why do I need to submit an Attending Physician Statement?**
   The Attending Physician Statement is required when a leave is being reviewed for STD pay.

10. **How will I be paid STD?**
    You will be paid STD through your regular weekly or monthly direct deposit. An STD pay schedule will be attached to your approval notice.

11. **I’m not eligible for FMLA. Can I apply for Short Term Disability?**
    Yes, if you are a full-time benefits eligible employee.

12. **Am I required to submit a return to work note? Is there a specific form?**
    When returning from leave for your own serious health condition, you are required to submit a return to work note. No note is required when returning from Paid Parental Leave or a leave for the care of a family member. You are not required to use a specific form, but we do have one available.
EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

LEAVE ENTITLEMENTS
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child’s birth or placement);
- To care for the employee’s spouse, child, or parent who has a qualifying serious health condition;
- For the employee’s own qualifying serious health condition that makes the employee unable to perform the employee’s job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee’s spouse, child, or parent.

An eligible employee who is a covered servicemember’s spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer’s normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual’s FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligible employees who work for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave; and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee’s worksite.

*Special “hours of service” requirements apply to airline flight crew employees.

REQUESTING LEAVE
Generally, employees must give 30-days’ advance notice of the need for FMLA leave. If it is not possible to give 30-days’ notice, an employee must notify the employer as soon as possible and, generally, follow the employer’s usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES
Once an employer becomes aware that an employee’s need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for its determination.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE
(1-866-487-9243)  TTY: 1-877-889-5627
www.dol.gov/whd

U.S. Department of Labor  |  Wage and Hour Division
The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member’s health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees’ family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____________________________________________________________________________________
First         Middle         Last

(2) Employer name: ____________________________________________________   Date: _________________ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by __________________________ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee’s diligent, good faith efforts.)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member’s health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days. 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: __________________________

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse       ☐ Parent       ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms “child” and “parent” include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.
Employee Name: ____________________________________________________________________________________________

(3) Briefly describe the care you will provide to your family member: (Check all that apply)

☐ Assistance with basic medical, hygienic, nutritional, or safety needs  ☐ Transportation

☐ Physical Care ☐ Psychological Comfort  ☐ Other: ____________________________________________________________________________________________

(4) Give your best estimate of the amount of leave needed to provide the care described:

______________________________________________________________________________________________________

(5) If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work. From ____________________________ (mm/dd/yyyy) to ____________________________ (mm/dd/yyyy). I am able to work ____________________________ (hours per day) ____________________________ (days per week).

Employee Signature __________________________________________________________ Date ____________________________ (mm/dd/yyyy)

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient’s serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider’s name: (Print) ______________________________________________________________________

Health Care Provider’s business address: ___________________________________________________________________

Type of practice / Medical specialty: ______________________________________________________________________

Telephone: (_____) ________________ Fax: (____) ______________ E-mail: _______________________________________

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For FMLA purposes, “incapacity” means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b).

(1) Patient’s Name: ______________________________________________________________________________________

(2) State the approximate date the condition started or will start: ____________________________ (mm/dd/yyyy)

(3) Provide your best estimate of how long the condition lasted or will last: ____________________________

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

______________________________________________________________________________________________________

Page 2 of 4 Form WH-380-F, Revised June 2020
Employee Name: ________________________________

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ Inpatient Care: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): ______________________________

☐ Incapacity plus Treatment: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from ________________ (mm/dd/yyyy) to ________________ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): ______________________________

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

☐ Pregnancy: The condition is pregnancy. List the expected delivery date: ________________ (mm/dd/yyyy).

☐ Chronic Conditions: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ Permanent or Long Term Conditions: (e.g. Alzheimer’s, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ Conditions requiring Multiple Treatments: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ None of the above: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) ______________________________________________________________

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine if the benefits and protections of the FMLA apply.

(7) Due to the condition, the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): ______________________________

(8) Due to the condition, the patient (☐ was / ☐ will be) referred to other health care provider(s) for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) ______________________________

Provide your best estimate of the beginning date ________________ (mm/dd/yyyy) and end date ________________ (mm/dd/yyyy) for the treatment(s).

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week) ________________________________
Employee Name: ____________________________________________________________

(9) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _______________ (mm/dd/yyyy) and end date _______________ (mm/dd/yyyy) for the period of incapacity.

(10) Due to the condition, (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _______________ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _______________ (☐ hours / ☐ days) per episode.

Signature of
Health Care Provider _____________________________ Date ___________________________ (mm/dd/yyyy)

**Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)**

<table>
<thead>
<tr>
<th>Inpatient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An overnight stay in a hospital, hospice, or residential medical care facility.</td>
</tr>
<tr>
<td>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</td>
</tr>
</tbody>
</table>

**Incapacity Plus Treatment:** A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health care provider might prescribe a course of prescription medication or therapy requiring special equipment.

**Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care.

**Chronic Conditions:** Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

**Permanent or Long-term Conditions:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer’s disease or the terminal stages of cancer.

**Conditions Requiring Multiple Treatments:** Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.
Real People, Real Stories

“I got the right support at a tough time.”

Don received a difficult diagnosis and dealing with it was affecting his work. Health Advocate helped clarify his diagnosis, lined up a specialist for a second opinion and provided short-term counseling to help him with coping strategies.

We’re here when you need us most
Your Health Advocate benefit can be accessed 24/7. Normal business hours are Monday - Friday, from 8 am to 11 pm, Eastern Time (ET). Staff is available for assistance after hours and on weekends.

There is no cost to use our service
Your employer or plan sponsor offers your Health Advocate benefit at no cost to you.

We’re not an insurance company
West’s Health Advocate Solutions is not affiliated with any insurance or third party provider, and does not replace health insurance coverage, provide medical care or recommend treatment.

Your privacy is protected
Our staff carefully follows protocols and complies with all government privacy standards. Your medical and personal information is kept strictly confidential.

Welcome to Health Advocate!

Personal healthcare help anytime, anywhere

Our experts make healthcare easier, by supporting you and your eligible family members with a wide range of health and insurance-related issues through a single toll-free number.

Turn to us—we can help.
866.799.2329
Email: answers@HealthAdvocate.com
Web: HealthAdvocate.com/upenn

Download the app today!

Real People, Real Stories

“I got the right support at a tough time.”

Don received a difficult diagnosis and dealing with it was affecting his work. Health Advocate helped clarify his diagnosis, lined up a specialist for a second opinion and provided short-term counseling to help him with coping strategies.
Welcome to Health Advocate
This guide provides an overview of Health Advocate and its many services. If you need assistance or have questions, simply call the toll-free number for prompt support.

One number, complete support
Our Personal Health Advocates are familiar with your entire employee benefits package. They can explain your coverage, answer your questions, and if you need to reach a specific benefit, they can connect you right away.

Expert healthcare help
They are also experts at navigating the complicated healthcare and insurance systems. They’ll do the paperwork, make the calls and cut through the red tape to resolve a wide range of issues.

They can:
- Support medical issues, from common to complex
- Answer questions about diagnoses and treatments
- Research the latest treatment options
- Coordinate services related to all aspects of your care
- Find the right in-network doctors and make appointments
- Coordinate second opinions and transfer medical records
- Research and locate eldercare services

Confidential help with personal issues
Your Employee Assistance Program provides confidential access to a Licensed Professional Counselor for help with personal, family and work issues. If needed, we can refer you to qualified professionals for more long-term support. In a crisis, help is available 24/7.

- Relationship/family issues, parenting
- Job concerns, burnout, coworker conflicts
- Depression, anxiety, anger, grief, loss, addiction, substance abuse
- Find services for childcare and eldercare
- Legal/financial consultation and services

Plus, easy access to your customized website and mobile app for articles, tips, tools and more!

Who is covered?
Health Advocate is available to employees, spouses, dependents, parents and parents-in-law.

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