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](mailto: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](mailto: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

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

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.

An employee who works 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.

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 ineligibility.

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 protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’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 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.)

(4) Employee’s job title: ___________________________________________ Job description (☐ is / ☐ is not) attached.
   Employee’s regular work schedule: ________________________________
   Statement of the employee’s essential job functions: ________________________________
   (The essential functions of the employee’s position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. 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 on page 4.

You 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.
PART A: Medical Information

Limit your response to the medical condition(s) 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) State the approximate date the condition started or will start: ___________________________________ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: ____________________________________

(3) 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.
(4) 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 FMLA coverage.

(5) 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): ___________________________

(6) 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) ___________________________

(7) Due to the condition, it is medically necessary for the employee to work a reduced schedule.

Provide your best estimate of the reduced schedule the employee is able to work. From ___________ (mm/dd/yyyy) to ___________ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week) ___________________________

(8) 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.

(9) Due to the condition, it (□ was / □ is / □ will be) medically necessary for the employee to be absent from work 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.
PART C: Essential Job Functions
If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee’s essential functions or a job description, answer these questions based upon the employee’s own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

______________________________________________ Date ____________________________ (mm/dd/yyyy)

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

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

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 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.
Please Note: The information on this form may not be sufficient to support the employee’s inability to perform his/her essential job functions; therefore please include the following whenever possible: most recent office visit notes, diagnostic test results, operative report (if applicable) and physical therapy notes (if applicable).

## EMPLOYEE INFORMATION

### Section 1: Employee Information

<table>
<thead>
<tr>
<th>EMPLOYEE NAME:</th>
<th>EMPLOYEE EMAIL:</th>
<th>EE ID:</th>
<th>DATE OF BIRTH:</th>
<th>JOB TITLE/DESCRIPTION:</th>
</tr>
</thead>
</table>

### TO BE COMPLETED BY ATTENDING PHYSICIAN:

#### Section 2: Complete this Section for Pregnancy

<table>
<thead>
<tr>
<th>Expected Delivery Date (mm/dd/yyyy):</th>
<th>Actual Delivery Date (mm/dd/yyyy):</th>
<th>Delivery Type:</th>
<th>Date of first visit for this pregnancy (mm/dd/yyyy):</th>
<th>Date Hospitalized (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ Vaginal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ C-Section</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>ICD Code:</th>
<th>Did you advise your patient to cease working prior to delivery?</th>
<th>If yes, what date? (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ YES ☐ NO</td>
<td></td>
</tr>
</tbody>
</table>

Were there any complications that caused your patient to cease working prior to the expected delivery date? ☐ YES ☐ NO If yes, please provide explanation:

#### Section 3: Complete this section for all conditions

<table>
<thead>
<tr>
<th>Primary Diagnosis:</th>
<th>Primary ICD Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Secondary Diagnosis:</th>
<th>Secondary ICD Code:</th>
</tr>
</thead>
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<tr>
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<td></td>
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</tbody>
</table>

Please describe symptoms, including frequency, severity, and duration:

<table>
<thead>
<tr>
<th>Date of first visit for the current condition(s) (mm/dd/yyyy):</th>
<th>Date of last visit (mm/dd/yyyy):</th>
<th>Date of next visit (mm/dd/yyyy):</th>
<th>Frequency of treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☐ Weekly ☐ Monthly ☐ Other</td>
</tr>
</tbody>
</table>

Has the patient been treated for the same or similar condition in the past? ☐ YES ☐ NO ☐ Unknown

If Yes, provide treatment dates: From: Through:

<table>
<thead>
<tr>
<th>Is the patient’s condition work related?</th>
<th>Did you advise the patient to stop working?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ YES ☐ NO ☐ Unknown</td>
<td>☐ YES ☐ NO If yes, date:</td>
</tr>
</tbody>
</table>

Has the patient been hospitalized for this condition? ☐ YES ☐ No

If Yes, provide date hospitalized: From: Through:

Was surgery performed? ☐ YES ☐ NO If Yes, what was the procedure?

<table>
<thead>
<tr>
<th>Patients Height:</th>
<th>Patients Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code:</th>
<th>Date Surgery performed (mm/dd/yyyy):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please describe your current treatment plan and include all medications with prescribed dosage:

Please comment on how cooperative and compliant the patient has been with current treatment plan:

Additional Providers: Are you aware of or have you referred your patient to any additional treating providers? ☐ YES ☐ NO If Yes, please provide the provider’s name and contact information.
### ATTENDING PHYSICIAN STATEMENT

**UNIVERSITY OF PENNSYLVANIA**  
**HUMAN RESOURCES - BENEFITS**  
FAX: (215)405-2929 EMAIL: FMLA@hr.upenn.edu

<table>
<thead>
<tr>
<th>Name:</th>
<th>Specialty:</th>
<th>Address:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- **Has the patient been advised to return to work?**  
  - □ YES  
  - □ NO

- **What is the expected return to work date? (mm/dd/yyyy):**  
  - □ Full Time  
  - □ Part Time  
  - Part Time hours per day:

- **How is your patient limited from performing his/her occupation and what prevents a return to work with full or partial duties?**

- **What are the patients restrictions (what the patient should not do) and why?**

- **What diagnostic tests or clinical exam findings support your patients work restrictions and limitations? Please include results of any examination, lab data, x-rays, EKGs, and MRI:**

- **Are there any non-medical factors which have a significant impact on functional abilities? (Please consider the following: Work place issues (ie problems with supervisor, performance); Social/Family issues; Alcohol/Drug abuse; Financial/Legal issues):**

### Section 4: Psychological Functions:

- **Check Applicable box below:**
  - □ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
  - □ Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations)
  - □ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
  - □ Class 4 – Patient is unable to engage in stress situations and engage in interpersonal relations (marked limitations)
  - □ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations)

- **Remarks:**

- **What stress factors or problems with interpersonal skills have affected patient’s ability to perform the duties of his or her job?**

- **Is patient competent to endorse checks and direct use of proceeds?**  
  - □ Yes  
  - □ No
### Section 5: Physical Capabilities:

<table>
<thead>
<tr>
<th>(1) Patient’s ability to:</th>
<th>(2) Patient’s ability to: (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climb</td>
<td>Continuous intermittently</td>
</tr>
<tr>
<td>Twist/bend/stoop</td>
<td>Continuous intermittently</td>
</tr>
<tr>
<td>Reach above shoulder level</td>
<td>Continuous intermittently</td>
</tr>
<tr>
<td>Operate a motor vehicle</td>
<td>Continuous intermittently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hours (circle)</th>
<th>(check)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit 1 2 3 4 5 6 7 8 □ Continuously □ intermittently</td>
<td></td>
</tr>
</tbody>
</table>

| Stand 1 2 3 4 5 6 7 8 □ Continuously □ intermittently |
| Walk 1 2 3 4 5 6 7 8 □ Continuously □ intermittently |

### Section 6: Attending Physician Signature:

<table>
<thead>
<tr>
<th>(3) Patient’s ability to lift/carry: (check)</th>
<th>(4) Patient’s ability to perform repetitively: (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 10 lbs.</td>
<td>Fine finger movements Right Hand Left Hand</td>
</tr>
<tr>
<td>11 to 20 lbs.</td>
<td>Eyelid movements Right Hand Left Hand</td>
</tr>
<tr>
<td>21 to 50 lbs.</td>
<td>Pushing/pulling Right Hand Left Hand</td>
</tr>
<tr>
<td>51 to 100 lbs.</td>
<td>Dominant Hand Right Hand Left Hand</td>
</tr>
<tr>
<td>Over 100 lbs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently 1-35%</th>
<th>36-66%</th>
<th>67-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

| (5) In your opinion, why is the patient unable to perform duties? |

| (6) Do you expect improvement in any area? (If so, please comment and give dates/timeframes.) |

### The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking, that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual’s family member or an embryo lawfully held by an individual or family member receiving assisted reproductive services.
Return to Work Release Form

**Physician Certification:** Upon return to work, employees absent more than three (3) work days due to illness must provide a physician's certificate or other written statement showing the cause or nature of the illness or injury and release for duty.

**TO BE COMPLETED BY THE EMPLOYEE:**

Employee: ________________________________________________________________________________________

Department: _______________________________ Department Phone: ______________________________

**TO BE COMPLETED BY THE HEALTHCARE PROVIDER:**

Employee may:

____ Return to work on _______________ (date) without restrictions

____ Return to work on _______________ (date) with restrictions as indicated below through _______________ (date)

If modified duty meeting these restrictions is not available, the employee will be considered off work until released without restrictions.

Please list restrictions or limitations below:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Name of Health Care Provider: ________________________________ Provider Phone: ________________________________

Provider Signature: ________________________________ Provider Fax: ________________________________

Today's Date: ________________________________
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.

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 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.

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.
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.