



# 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 spouse, child or parent who has a serious health condition
    - Spouse  Child: Age \_\_\_\_\_  Parent
  - Placement of a child with me for adoption or foster care
  - 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 note from my physician stating that I am able to return to work 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, 600 Franklin Building, 3451 Walnut Street, Philadelphia, PA 19104-6205  
Fax No: 215-573-7385

## 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](http://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 600 Franklin Building, 3451 Walnut Street, Philadelphia, PA 19104-6205. 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 is eligible 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 600 Franklin Building, 3451 Walnut Street, Philadelphia, PA 19104-6205, Fax: 215-573-7385.