CERTIFICATION OF HEALTHCARE PROVIDER

To comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and, as applicable, the California Genetic Information Nondiscrimination Act of 2011 (CalGINA), we are asking that you not provide any genetic information when responding to this request for information. "Genetic information," as defined by GINA and CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. "Genetic information" does not include information about an individual's sex or age.

PART A: TO BE COMPLETED BY THE ASSOCIATE

Associate Name (please print): _____ Employee ID # (see pay stub): _____

Personal Email Address: _____

By providing my personal email address, I authorize its use to receive notices about you leave of absence.

Current Work Schedule (# of weekly hours): _____ Work Location #: _____

What is the reason for your leave of absence request?

- ☐ Associate's own serious health condition, OR
- ☐ For pregnancy, childbirth or related medical conditions, OR
- ☐ For bonding with a newborn, newly adopted or foster child, OR
- ☐ To care for a family member (see definitions on page 4) with a serious health condition

If leave is requested to care for a covered family member, please:

Describe the care you need to provide: _____

Please provide an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced work schedule: _____

Does your spouse work for the Company or a subsidiary?

☐ No ☐ Yes If yes, Spouse's Name: _____ Employee ID #: _____

Authorization

I hereby request and authorize any qualified healthcare provider completing this form to release to the Company any and all information requested on this form regarding the condition(s) for which I am seeking leave. I also authorize a human resources professional representing my employer to contact my healthcare provider for verification of the authenticity of this certificate and to clarify the information provided. I agree that this authorization will be valid until my request for leave and any subsequent leave extension has been finally resolved. I understand that I may revoke this authorization at any time by written notification to the healthcare providers previously authorized, but that my revocation will not apply to any use or disclosure of my health information previously made in reliance on this authorization. I understand that I have a right to request and receive a copy of this authorization. A copy of this authorization shall be considered as effective and valid as the original.

_____ _____

ASSOCIATE SIGNATURE DATE

_____ _____

PATIENT'S SIGNATURE (IF NOT ASSOCIATE) DATE

Associate must return a fully completed form within **15 days** to the address, email or fax # below. A late or incomplete form may result in delay or denial of FMLA leave.

Centralized Leave of Absence Team 20227 N. 27th Avenue, Ste. 100 Phoenix, AZ 85027	**Email** leaveofabsence@albertsons.com	**FAX #** 623-336-6305

IMPORTANT: Please print your name and employee ID # at the top of pages 2 and 3 of this form.

Associate Name (please print): _____ Employee ID #: _____

PART B: TO BE COMPLETED BY PATIENT'S HEALTHCARE PROVIDER (pages 2 & 3)

INSTRUCTIONS TO THE HEALTHCARE PROVIDER: The associate listed above has requested leave under the FMLA or other state/local law for themselves or to care for your patient. Answer fully and completely all applicable parts. Several questions seek a response regarding the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and patient examination. Be as specific as you can, but we are not seeking a diagnosis or disclosure of the nature of any underlying medical conditions without the patient's consent. Please limit your responses to the condition(s) for which the associate is seeking leave. Be sure to sign the form at the bottom of page 3 and print clearly and legibly.

PLEASE COMPLETE SECTION 1 AND THE CORRESPONDING QUESTIONS (EITHER SECTION 2 OR SECTION 3) BASED ON THE TYPE OF LEAVE REQUESTED BY THE ASSOCIATE.

SECTION 1

1) Patient's name (if associate, state associate's name): _____

2) Date treated/examined: _____

3) "Serious Health Condition" is defined on page 4. Doers the patient's condition qualify as a serious health condition? ☐ Yes ☐ No

4) State the approximate date the medical condition, injury or illness or need for treatment commenced.
(Note: Do not disclose underlying diagnosis without the consent of the patient): _____

5) State the probable duration of the medical condition, injury or illness or need for treatment: _____

SECTION 2

REQUEST FOR LEAVE FOR ASSOCIATE'S OWN HEALTH CONDITION

If the associate is **not** requesting leave for their own health condition, skip this section.

1) Is the patient able to perform work of any kind? Please ask the associate to provide a job description if available or discuss with the associate the essential functions of their job. ☐ Yes ☐ No

2) If the associate may need to work a reduced schedule or intermittently, are there any limitations or their ability to perform their job functions? Please ask the associate to provide a job description if available or discuss with the associate the essential functions of their job.

☐ Yes ☐ No If yes, describe the limitation(s): _____

3) Is leave needed due to complications or pregnancy, prenatal care, childbirth, or a related medical condition?

☐ Yes ☐ No If yes, what is the estimated delivery due date or date of birth? _____

4) List the duration of the incapacity or periods of treatment (check one).

☐ **Continuous**: Start date: _____ End date: _____

☐ **Intermittent**: Please include episodes of incapacity, flare-up or medical appointments/treatment)

Start date: _____ End date: _____

Frequency: _____ times per _____ week(s) / _____ month(s)

Duration: _____ hour(s) or _____ day(s) per episode

☐ **Reduced Schedule** (e.g. maximum hours able per day):

Start date: _____ End date: _____

_____ hour(s) per day, _____ day(s) per week

If the certifying healthcare provider offers chiropractic services, please complete the following questions:

1) Were x-rays taken? ☐ Yes ☐ No

2) Is the treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist? ☐ Yes ☐ No

Associate Name (please print): _____ Employee ID #: _____

PART B (continued)

SECTION 3

REQUEST FOR LEAVE TO CARE FOR A FAMILY MEMBER

If the associate is **not** requesting leave to care for a family member, skip this section.

1) Is the patient is not the associate, does the patient require assistance with recovery, basic medical or personal needs, personal safety, transportation needs or psychological comfort? ☐ Yes ☐ No

   If yes, describe the care to be provided: _____

2) If leave is to care for a child over the age of 18, is the child unable to care for themselves due to a disability? ☐ Yes ☐ No ☐ N/A

3) After review of the associate's signed statement (page 1), does the condition warrant the need of participation by the associate? Participation may include psychological comfort and/or arranging for third-party care for the family member.

   ☐ Yes ☐ No

4) List the type of need for associate's participation in caring for the family member (check one):

   ☐ **Continuous**: Start date: _____ End date: _____

   ☐ **Intermittent**: Please include episodes of incapacity, flare-up or medical appointments/treatment)

   Start date: _____ End date: _____

   Frequency: _____ times per _____ week(s) / _____ month(s)

   Duration: _____ hour(s) or _____ day(s) per episode

SECTION 4

HEALTHCARE PROVIDER SIGNATURE

The healthcare provider certifies by their signature below that the information provided above is true and accurate.

_____ _____

NAME OF HEALTHCARE PROVIDER (please print) DEGREE OF HEALTHCARE PROVIDER

_____ _____

HEALTHCARE PROVIDER'S SIGNATURE TYPE OF PRACTICE

_____ _____

ADDRESS TELEPHONE NUMBER

_____ _____

DATE COMPLETED FAX NUMBER

Associate must return a fully completed form within **15 days** to the address, email or fax # below. A late or incomplete form may result in delay or denial of FMLA leave.

Centralized Leave of Absence Team
20227 N. 27th Avenue, Ste. 100
Phoenix, AZ 85027

Email
leaveofabsence@albertsons.com

FAX #
623-336-6305

DEFINITIONS

A “family member” means the following under the Family Medical Leave Act (FMLA):

- “**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.
- “**Child**” means biological, adopted, foster child, a stepchild, a legal ward who is either under the age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time the leave is to commence.
    - Under applicable state leave laws (e.g., California Family Rights Act) the definition of a child is expanded and may include child of the domestic partner.
- “**Parent**” means biological, adoptive, step or foster father or mother.
    - Under applicable state leave laws (e.g., California Family Rights Act) the definition of parent is expanded and may include parent-in-law and legal guardian.
- The terms “child” and “parent” include loco parentis relationships in which a person assumes the obligations or a parent to a child. An associate may take FMLA leave to care for an individual who assumed the obligations or a parent to the associate when the associate was a child. An associate may also take FMLA leave to care for a child for whom the associate has assumed the obligations of a parent. No legal or biological relationship is necessary.
- Under applicable state leave laws (e.g., California Family Rights Act) the definition of a family member is expanded and may include grandparent, grandparent-in-law, grandchild, sibling, stepsibling, a person related by blood, legal custody or marriage or designated person.
    - The term “designated person” means any individual related by blood or whose association with the associate is the equivalent of a family relationship. A designation form must be completed at the time the associate requests leave. Associates are limited to one designated person in a 12-month period.

A “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves one or more of the following:

Hospital Care

- Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity1 or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an “inpatient” when a health care facility formally admits him or her to the facility with the expectation the he or she will remain at least overnight.

Absence Plus Treatment

- A period of incapacity of more than three consecutive full calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:
    - treatment 2 two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, by direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of or on referral by a health care provider; or
    - treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

Pregnancy

- Any period of incapacity due to pregnancy or for prenatal care. [Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under the FMLA but may not be under certain state laws, such as the California Family Rights Act.

Chronic Conditions Requiring Treatments

- A chronic condition which: (1) requires periodic visits (at least twice a year) for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider; (2) continues over an extended period of time (including recurring episodes of a single underlying condition); (3) may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, migraine headaches, etc.).

Permanent/Long-term Conditions Requiring Supervision

- A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal states of a disease.

Multiple Treatments (Non-chronic Conditions)

- Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of or on referral by a health care provider, either for restorative surgery after an accident or other injury or for a condition that would likely result in a period of incapacity1 of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

A serious health condition does not include conditions for which cosmetic treatments are administered (such as most treatments for acne or plastic surgery) unless inpatient hospital care is required or unless complications develop. Ordinarily, unless complications arise, the common cold, the flu, earaches, upset stomach, minor ulcers, headache other than migraine, routine dental or orthodontia problems, periodontal disease, etc. are examples of conditions that do not meet the definition of a serious health condition.

- "Incapacity" for purposes of FMLA is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment thereto or recovery therefrom.
- "Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
- A "regimen of continuing treatment" includes, for example, a course or prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate a health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.