HEALTHCARE PROVIDER STATUS FORM

PART A: TO BE COMPLETED BY THE ASSOCIATE

Associate (Patient) Name (please print): _____

Employee ID #: _____ Store/ Location #: _____ Associate (Patient) Phone #: _____

Most Recent Position/Title: _____ Associate Personal Email (if available): _____

Authorization

I hereby authorize the healthcare provider designated below to release information acquired in the course of my examination or treatment as follows:

- I authorize the below healthcare provider to provide information on this form to Human Resources/the Leave Administrator to establish whether our employee has a medical condition or one or more physical or mental condition(s) (as defined under applicable federal, state or local law) that limit one or more major life activities, the need for a reasonable accommodation and a description of any functional limitations that effect my ability to perform my job or a desired job.
- I understand that further clarification may be needed by Human Resources to determine whether a reasonable accommodation can be made that would enable me to perform the essential duties of my current, or an alternate, position. Therefore, I further authorize the healthcare provider designated below to provide additional information to me to provide to the Company if the information provided initially is insufficient to establish the existence of a disability and/or the availability of a reasonable accommodation.
- This authorization will expire within one year of my signature or upon my written revocation in a letter to the Company, whichever date is sooner.

_____ _____

ASSOCIATE SIGNATURE DATE

PART B: TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

Please complete the information below **immediately prior to the patient's return to work (if they were on leave)**.

INSTRUCTIONS TO HEALTHCARE PROVIDER: The healthcare provider should not provide the nature of the associate's physical or mental condition, nor his/her diagnosis; **that information is not necessary for the completion of this form.** 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

Prior to completing this form, I have discussed with the associate his/her job duties and/or reviewed this associate's most recent job description for his/her position.

Please choose one of the following:

☐ The associate is being released to his/her most recent position with **NO RESTRICTIONS** effective _____

OR

☐ **The associate is not able to return to work at this time, even with restrictions**. If this associate has a medical condition or a mental and/or physical condition (as defined under applicable federal, state, or local law) that limits (makes difficult) a major life activity, including any condition that limits his/her ability to work or perform one or more functions of his/her job. Please select one of the following options, fill in required information and then proceed to the signature section of this form:

- ☐ A leave of absence extension will be effective in returning the associate to work in the future with or without restrictions. If so, please estimate the return-to-work date _____, and explain why you believe the extension will be effec□ve (i.e. treatments or therapy will be completed): (REQUIRED)

OR

- ☐ A leave of absence extension will not be effective in returning the associate to work at this time or in the future.

OR

☐ The associate is able to return to work with restrictions effective _____, for _____ hours per day, _____ days per week with the restriction(s) on the following page.

PART B: TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY (continued from prior page)

Please check the appropriate boxes or describe below the restrictions for each applicable job function as indicated:

JOB FUNCTION	FREQUENCY					
	Never	Occasionally (0-33%)	Frequently (34% to 66%)	Continuously (67% - 100%)	Estimated Duration	No Restrictions
Lift or Carry						
Up to 10 lbs.						
11—24 lbs						
25-35 lbs						
36—50 lbs						
51-70 lbs						
71—90 lbs						
Push / Pull						
Reach Above Shoulder (Max of _____ lbs)						
Reach Over Head (Max of _____lbs)						

JOB FUNCTION	FREQUENCY								
	Never	Intermit-tent	1-2 hrs	2-3 hrs	3-4 hrs	5-6 hrs	6-8 hrs	Estimated Duration	No Restrictions
Sit									
Stand.									
Walk									
Repetitive Use of Hands									
Left									
Right									
Bend/Stoop									

OTHER JOB FUNCTION	HOW IS FUNCTION LIMITED BY THE CONDITION Note: Include only the limitations; we will engage interactively with the associate about potential accommodations to overcome the limitations.	ESTIMATED DURATION OF LIMITATION
Example: Receive/follow instructions	Example: Associate requires instructions both in writing and verbal format	Example: 12 months—then revisit
Example: Shift schedule	Example: Requires breaks when alerted to low blood sugar levels to allow for a snack	Example: permanent

Date of this exam: _____ Date of Next Scheduled exam: _____

Healthcare Provider's Signature: _____

Healthcare Provider's Credentials/title (e/g/ physician or psychologist): _____

Print Healthcare Provider's Name: _____ Phone: _____

Please fax this completed form to 1-623-336-6305 or scan and email to **leaveofabsence@albertsons.com**. For questions, please contact the AEC at 1-888-255-2269 option 6.