

FAMILY AND MEDICAL LEAVE OF ABSENCE (FMLA) ADVANCE REQUEST FORM

FOR EMPLOYEE TO COMPLETE

Employee's Name _____ SSN _____

Title/Division _____

Expected Leave Start Date _____ Expected Leave End Date _____

Purpose of Leave:

- 1. Birth of my child
- 2. Adoption of my child
- 3. Foster care placement of a child in my care
- 4. Care of an immediate family member (spouse, parent, or child) with a serious health condition

Name of family member _____

Relationship to employee _____

Serious health condition:

5. Employee's own serious health condition (Describe): _____

6. Other Reason _____

Request for Reduced or Intermittent Leave:

Please state your need for reduced or intermittent leave and a suggested schedule of leave time away from your job (attach additional information to this form if necessary). _____

Medical Certification:

J. R. Simplot Company generally requires that medical conditions be substantiated by a certification from a health care provider to verify the employee (or immediate family member) has a *serious health condition* which qualifies for coverage under the FMLA. The Certification of Health Care Provider Form is a separate document available from your HR representative. Approval of any medically-related leave may be subject to the information provided by the health care provider.

Payment of Health Care and Other Benefits During an Approved Leave of Absence:

I agree to continue paying my share of premiums by direct payment or payroll accrual for any medical, dental, and/or vision coverage which I am enrolled in prior to taking a leave of absence. I understand that I will be notified of the premium amount separately and will submit my payment promptly to the company to continue my coverages. I understand that the company has the right to cancel my benefits if I fail to make the required premium payments. If my coverages lapse, I understand that the company will reinstate any coverages I had without restriction once I return to active employment.

Employee Signature

Date

FOR EMPLOYER USE ONLY

Based on review of this form and the medical certification form (if applicable), leave is ELIGIBLE under the FMLA and will be charged against employee's entitlement. FMLA leave is unpaid (Leave for personal illness/injury may be paid under a short term disability policy or workers' compensation). NOTICE: Eligibility for continuing leave may be redetermined from time to time.

Based on review of this form and the medical certification form (if applicable), leave is NOT ELIGIBLE under the FMLA and will not be counted toward the employee's entitlement. Leave is approved under the applicable vacation/leave of absence policy and is subject to the guidance set forth in that policy.

Leave of absence is not covered by federal or state law or appropriate under company policy and is therefore not approved.

HR Representative or Supervisor

Date

PROVIDE COPY TO EMPLOYEE WITH FMLA RIGHTS FORM (EXHIBIT D) Hand delivery Mail

FAMILY AND MEDICAL LEAVE OF ABSENCE (FMLA) NOTIFICATION FORM
(TO BE USED WHEN EMPLOYEE HAS NOT COMPLETED REQUEST FORM.)

Employee's Name _____ SSN _____

Title/Division _____

Expected Leave Start Date _____ Expected Leave End Date _____

Purpose of Leave:

- 1. Birth of employee's child
- 2. Adoption of employee's child
- 3. Foster care placement of a child in employee's care
- 4. Care of an immediate family member (spouse, parent, or child) with a serious health condition
Name of family member _____
Relationship to employee _____
Serious health condition: _____
- 5. Employee's own serious health condition (Describe): _____
- 6. Other reason: _____

Request for Reduced or Intermittent Leave:

Please state any communications from the employee regarding need for reduced or intermittent leave and a suggested schedule of leave time away from job (attach additional information to this form if necessary). _____

Medical Certification:

J. R. Simplot Company generally requires that medical conditions be substantiated by a certification from a health care provider to verify the employee (or immediate family member) has a *serious health condition* which qualifies for coverage under the FMLA. The Certification of Health Care Provider Form is a separate document available from your HR representative. Approval of any medically-related leave may be subject to the information provided by the health care provider.

Payment of Health Care and Other Benefits During an Approved Leave of Absence:

Your share of premiums must continue to be made by direct payment or payroll accrual for any medical, dental, and/or vision coverage in which you are enrolled prior to taking a leave of absence. You will be notified of the premium amount separately and must submit payment promptly to the company to continue coverages. The company has the right to cancel benefits if you fail to make the required premium payments. If your coverages lapse, the company will reinstate any coverages without restriction once you return to active employment.

Based on review of this form and the medical certification form (if applicable), leave is **ELIGIBLE** under the FMLA and will be charged against employee's entitlement. FMLA leave is unpaid (Leave for personal illness/injury may be paid under a short term disability policy or workers' compensation). **NOTICE:** Eligibility for continuing leave may be redetermined from time to time.

Based on review of this form and the medical certification form (if applicable), leave is **NOT ELIGIBLE** under the FMLA and will not be counted toward the employee's entitlement. Leave is approved under the applicable vacation/leave of absence policy and is subject to the guidance set forth in that policy.

Leave of absence is not covered by federal or state law or appropriate under company policy and is therefore not approved.

HR Representative or Supervisor

Date

SEND "CERTIFIED MAIL" TO EMPLOYEE WITH COVER LETTER AND
FMLA RIGHTS FORM (EXHIBIT D)

Exhibit B

**CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act)**

The purpose of this form is to determine whether the employee's medical condition qualifies as a disability leave and/or Family and Medical Leave ("FMLA").

1a. Employee's Name: _____ 1b. Social Security Number _____
2a Patient's Name: _____ 2b. Relationship to Employee _____
Patient's Name (if other than employee) _____

*TO BE COMPLETED BY EMPLOYEE REQUESTING DISABILITY LEAVE FOR HIS/HER OWN MEDICAL
CONDITION*

You are hereby authorized to release to **J.R. Simplot Company**, or any designated representative or surety thereof: 1) any and all relevant information (including but not limited to my history and work restrictions) you may have relative to my condition while under your observation and treatment, and 2) hospital records for examination and copying, including photocopying. A photocopy of this authorization will be valid and should be accepted with the same effect as the original.

Employee signature: _____ Date: _____

*TO BE COMPLETED BY EMPLOYEE REQUESTING FMLA LEAVE TO CARE FOR AN IMMEDIATE FAMILY
MEMBER*

When family leave is needed to care for an immediate family member with a serious health condition, the employee shall state the care or participation he or she will provide and an estimate of time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

3a. Date medical condition commenced: _____ 3b. Date of most recent treatment: _____
4. Expected date employee should be able to return to his or her job: _____
5. Is it medically necessary for the employee to be absent from work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week? Yes ___ No ___. If yes, indicate a suggested schedule of treatments/absences and the expected duration of such treatments/absences.

6a. Does the employee or immediate family member have a *serious health condition* that meets one or more of the conditions listed a. through g. on the back of this form? Which condition? _____ None _____

6b. Please describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of the category checked above. _____

7a. Signature of health care provider: _____ 7b. Date: _____

8. Type of practice (field of specialization, if any): _____

9. Health care provider's address and telephone number: _____

[Employee Do Not Write Below This Point]

TO BE COMPLETED BY EMPLOYEE'S HR. REPRESENTATIVE

Designated as a qualified FMLA leave: ___yes ___no

H. R. Representative Signature: _____ Date: _____

Exhibit C

A serious health condition is an illness, injury, impairment, physical or mental condition that involves:

A. HOSPITAL CARE:

Inpatient care in a hospital, hospice, or residential care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

B. ABSENCE/MULTIPLE TREATMENT:

A period of incapacity of more than 2 calendar days that also involves treatment of two or more times by a health care provider, a nurse, or physician's assistant under direct supervision of a health care provider, or by a provider of health care services under order of, or on referral by, a health care provider.

C. ABSENCE/TREATMENT REGIMEN:

A period of incapacity of more than 3 calendar days that also involves 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.

D. PREGNANCY:

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

E. CHRONIC CONDITION:

A chronic condition which : (1) requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under the direct supervision of a health care provider; (2) continues over an extended period of time; and (3) may cause episodic rather than a continuing period of incapacity.

F. PERMANENT CONDITIONS:

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider.

G. MULTIPLE TREATMENTS:

Any period of absence to receive multiple treatments (including recovery) by a health care provider or be 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 incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment. (Such as chemotherapy for cancer).