Application for Leave for Health Reasons (LHR)

Non-work-related injuries or illness

This Application must be completed and submitted to your Manager whenever you are absent from work for medical reasons for more than **11 work days**. You must also complete and submit an updated Application if your doctor/Nurse Practioner extends your leave beyond the end-date specified on this Application. The information on this Application is required by the Company in order to establish your entitlement to a leave of absence for health reasons (LHR) and to allow the Company to appropriately plan its operations during your absence.

Instructions:

- Complete **Section A** in full and sign the Release & Acknowledgement
- **Section B** must be completed by your attending physician/NP before you submit the Application to your Manager.
  - Ask your physician/NP to complete a *Work Abilities Form* only if he/she is of the opinion that you will require modified duties upon your return to work.
- **Section C** must be completed by your Manager. If you are a Store colleague, this section must be completed by the Store Manager.
- Submit your completed Application to your Manager at the earliest time possible before your LHR commences, or as soon as possible thereafter.
- You must complete and submit another Application to extend your LHR, and for any subsequent LHRs.

Section A — To be completed by the colleague (please print clearly)

Colleague Last Name	Given Name(s) in Full		
HARRIETHA-NAZARI	KATHLEEN JOYCE	☐ Full-Time	☒ Part-Time

Colleague ID Number	Division Number	Store/Location #	Work Location
		644	524 BAYFIELD ST BARRIE, ON

Province of Work	Job Title	Manager's Name	Name of Human Resources or Labour Relations Manager
ON	CUSTOMER SERVICE REPRESENTATIVE	BERNADETTE FOUNTAIN	

I hereby request an *unpaid* leave for health reasons:

Last day of work: OCTOBER 27, 2020	**Start-date of LHR:** OCTOBER 28, 2020
End-date of LHR: UNKNOWN / TO BE DETERMINED	**Expected return-to-work date:** UNKNOWN / TO BE DETERMINED

Colleague Release & Acknowledgement

I hereby authorize my physician to release the information requested on this Application. I agree that the personal information provided herein may be used or disclosed as necessary to administer the LHR I have requested. I declare that the statements made by me in this Application are true and that provision by me of false or misleading information may result in disciplinary action.

I understand that during my authorized LHR I will still be responsible for paying any applicable health and dental premiums for any plan for which I am an eligible participant as of the date of this Application. I agree that any premiums owing upon my return to work shall be deducted from my earnings from my first pay following my return from LHR. If my employment ends during my LHR, I will pay all applicable arrears, and agree that any such arrears may be deducted by the Company from any final earnings owed to me.

I understand that if I fail to return to work or otherwise establish my entitlement to further leave on or before the return-to-work date provided for herein by my attending physician/NP, I will be on an unauthorized leave and may be deemed to have abandoned my employment with Loblaw.

K. Harnetha-Nazari — Colleague Signature (required)

2020/11/26 — Date yyyy/mm/dd (required)

Section B — To be completed by the colleague's MD/NP

Your patient, the Loblaw colleague named above, has requested a medical leave of absence from his/her employment. Loblaw requires the following non-diagnostic information in order to properly provide for the leave and any subsequent return to work.

Part 1 (required):

General nature of the patient's medical condition (***non-diagnostic information only***): Please print clearly: Anemia - Severe

Part 2 (required) Please check and complete the applicable section.

☐ **Patient may immediately resume full duties**
Due to the above medical condition, the patient was unable to attend work, even on a modified basis, from _____ yyyy/mm/dd to today's date, but may immediately resume full duties.

☐ **Patient may immediately resume work subject to medical restrictions**
Due to the above medical condition, the patient was unable to attend work, even on a modified basis, from _____ yyyy/mm/dd to today's date, but may immediately resume work subject to the medical restrictions and/or limitations ***detailed on the attached Work Abilities Form.***

☑ **Patient is presently UNABLE TO WORK, even on a modified basis,** and has been unable to attend work for medical reasons since Oct 28/20 yyyy/mm/dd. **Select one of the following:**

- ☐ a. The patient is not expected to be able to return to his/her job in the future.
- ☒ b. A return-to-work date is not yet known. The next medical reassessment date is: in 2 months yyyy/mm/dd
- ☐ c. The patient is expected to be able to return to work on _____ yyyy/mm/dd, and will be
  - ☐ able to resume full duties
  - ☐ subject to the medical restrictions and/or limitations described on the attached ***Work Abilities Form***

IMPORTANT: Section B continues on next page ...

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Colleague/Patient Last name, First name (please print)

HARRIETHA , KATHLEEN

Section B Continued [To be completed by the colleague's Physician]

Attending Physician's/NP Information:

Name: Specialty

Address: DR. JASON LO, M.D.
Suite 202 - 3000 Hwy 7 East
Markham, ON. L3R 6E1

Telephone#: Tel: 905-480-1050 Fax#:
Fax: 905-480-0898

Signature: Date Form Completed: 2020/12/03

Section C To be completed by the colleague's Manager

Sections A and B must be completed by the colleague and his/her physician before you complete this section.

Important: This Application must be submitted to you for a colleague's request for leave for health reasons **longer than five days**. Upon your receipt of this Application, please sign and date below and place in the colleague's file at your location. For all requests for leave **exceeding 11 calendar days**, submit an LHR Claim to Windley Ely using their online reporting tool, and send a copy of this Application (and any accompanying forms or supporting documents) to:

Windley Ely Inc. by email to loblaw@windleyely.com or by fax to 1-877-947-2329

I acknowledge receipt of this completed Application for Leave for Health Reasons on the date specified below.

Manager's Name (please print) Signature Date

NOTE TO LOBLAW: APPLICATION NOTES MY LAST NAME AS MY MAIDEN NAME PLUS MY MARRIED NAME "HARRIETHA - NAZARI".
ALL MY MEDICAL RECORDS ARE IN MY MAIDEN NAME "HARRIETHA" ONLY.

K. Harrietha (- Nazari)