HOC

From: Stallberg C (Chad) MEG [stallbc@meglobal.biz]
Sent: Wednesday, November 29, 2023 10:52 AM
To: hoc@quikus.com
Subject: Emailing: Chad Stallberg MEGlobal_Employee_Health_Certification_Form_USA-SL Office- updated
Attachments: MEGlobal_Employee_Health_Certification_Form_USA-SL Office- updated.pdf

Please fill out Section 3, and email form back to me. I believe I was told I could return to work after a week with restrictions. I don't normally work weekends, so I am hoping to return to work by 12-18-23...but I am leaving that up to you guys. Please reach out to me (979-292-6529) if you have any questions.

Thanks,
Chad Stallberg

Your message is ready to be sent with the following file or link attachments:

MEGlobal_Employee_Health_Certification_Form_USA-SL Office- updated

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.

Employee Health Certification Form

Return completed form to Donia Muturi via email: dmuturi@meglobal.biz

This form is used to:
1. Determine an employee's eligibility to qualify for benefits under MEGlobal Americas Inc. Paid Medical Leave Policy, and
2. To assess fitness for duty and assist in return-to-work planning

Stallberg, Chad	2753	29/08/1974
Employee Name (Last, First)	Employee ID #	Date of Birth: (DD/MM/YYYY)

Work Site:	Oyster Creek	Home or Cell Phone:	979-292-6529	Leader Name:	Clay Hammontree
Department:	Operations	Work Phone:		HR Contact:	S. Bielamowicz

First Date of Work Missed: (DD/MM/YYYY)	07/12/2023	Injury/Illness Occurred On: (DD/MM/YYYY)	12/10/2023
Anticipated Return to Work Date (if known): (DD/MM/YYYY)	12/18/23 unknown,		
Injury/illness is work related?	☑ No ☐ Yes (MEGlobal HR and EHS must be immediately notified of the injury/illness)		
Release of Medical Records:	I authorize the release of my Healthcare Provider's diagnosis/disposition, specific to this injury / illness, to MEGlobal Americas, its insurance carrier and/or All American Screening & Medical to assist with facilitating this medical leave. I certify the information I provided is accurate and complete to the best of my knowledge.		
Employee Signature:	Chad	Date: (DD/MM/YYYY)	01/12/2023

Medical Condition: (diagnosis, surgery type, etc.) meniscus tear Right Knee
Arthroscopy Right Knee 12/7/23

Work status and anticipated duration:
- ☐ Full Work Release (no work restrictions)
- ☑ Restricted Work (listed below) starting 12/18/23
- ☑ No Work Until Further Notice
- ☐ Hospitalized or Referred for Additional Evaluation/Treatment

Restrictions: (Check all that apply and provide details below for any YES) No work 12/7/23 - 12/18/23

Estimated duration of limitation(s): (DD/MM/YYYY)

☐ No ☑ Yes - Standing limited		☐ No ☐ Yes - Working Around Motorized Equipment / Machinery	
☐ No ☐ Yes - Upper Extremity Repetitive Motion: R L		☐ No ☑ Yes - Repeated Squatting or Bending none	
☐ No ☑ Yes - Walking limited		☐ No ☐ Yes - Vehicle Operation (includes any motorized equipment)	
☐ No ☑ Yes - Climbing Stairs / Ladders no ladders		☐ No ☑ Yes - Working at Heights none	
☐ No ☑ Yes - Lifting limited to 20 lbs.		☐ No ☐ Yes - Work in Areas with Dust, Fumes or Chemicals	
☐ No ☑ Yes - Strenuous Activities / Heavy Exertion none		☐ No ☐ Yes - Overtime Work Hours	
☐ No ☐ Yes - Overhead Work with Arms		☐ No ☐ Yes - Limited Work Hours	
☐ No ☐ Yes - High Dexterity Tasks with Hands		☐ No ☐ Yes - Other Restriction(s)	

Details of Limitations: (all YES's) No kneeling, squatting, pushing, pulling, lifting over 20lbs climbing ladders, excessive walking/standing

This condition is: ☑ Acute ☐ Chronic ☐ Pregnancy

12/18/23 - 1/18/24 same restrictions above

The likely duration and frequency of episodes of condition: 12/7/23 - 12/18/23 NW work

Healthcare Provider Name & Address:	201 Oak Dr. So Suite 104 Lake Jackson, TX 77566		
Telephone #: 979 297 3004		Healthcare Provider Signature	12/13/23 Date (DD/MM/YYYY)

MEGLOBAL RESTRICTED

Notice of Eligibility & Rights and Responsibilities under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND TO THE DEPARTMENT OF LABOR. PROVIDE TO EMPLOYER.

OMB Control Number: 1235-0003
Expires: 6/30/2026

In general, to be eligible to take leave under the Family and Medical Leave Act (FMLA), an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. §§ 825.300(b), (c) which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Date: 11/28/23 *(mm/dd/yyyy)*

From: MEGlobal Americas Inc. *(Employer)* To: Chad Stallberg *(Employee)*

On 11/27/23 *(mm/dd/yyyy)*, we learned that you need leave *(beginning on)* 12/07/23 *(mm/dd/yyyy)* for one of the following reasons: *(Select as appropriate)*

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ■ Your own serious health condition
- ☐ You are needed to care for your family member due to a serious health condition. Your family member is your:
  - ☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability
- ☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:
  - ☐ Spouse ☐ Parent ☐ Child of any age
- ☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:
  - ☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

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. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

SECTION I – NOTICE OF ELIGIBILITY

This Notice is to inform you that you are:

- ■ **Eligible for FMLA leave.** *(See Section II for any Additional Information Needed and Section III for information on your Rights and Responsibilities.)*
- ☐ **Not eligible for FMLA leave because:** *(Only one reason need be checked)*
  - ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately: _____ towards this requirement. *(months)*
  - ☐ You have not met the FMLA's 1,250 hours of service requirement. As of the first date of requested leave, you will have worked approximately: _____ towards this requirement. *(hours of service)*

Employee Name: Chad Stallberg

☐ You are an airline flight crew employee and you have not met the special hours of service eligibility requirements for airline flight crew employees as of the first date of requested leave (i.e., worked or been paid for at least 60% of your applicable monthly guarantee, and worked or been paid for at least 504 duty hours.)

☐ You do not work at and/or report to a site with 50 or more employees within 75-miles as of the date of your request.

If you have any questions, please contact: _____ *(Name of employer representative)*

at _____ *(Contact information).*

SECTION II – ADDITIONAL INFORMATION NEEDED

As explained in Section I, you meet the eligibility requirements for taking FMLA leave. Please review the information below to determine if additional information is needed in order for us to determine whether your absence qualifies as FMLA leave. Once we obtain any additional information specified below we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. If complete and sufficient information is not provided in a timely manner, your leave may be denied.

(Select as appropriate)

☐ No additional information requested. If no additional information requested, go to Section III.

☑ We request that the leave be supported by a certification, as identified below.

- ☑ Health Care Provider for the Employee
- ☐ Health Care Provider for the Employee's Family Member
- ☐ Qualifying Exigency
- ☐ Serious Illness or Injury *(Military Caregiver Leave)*

Selected certification form is ☐ attached / ☐ not attached.

If requested, medical certification must be returned by 12/22/23 *(mm/dd/yyyy) (Must allow at least 15 calendar days from the date the employer requested the employee to provide certification, unless it is not feasible despite the employee's diligent, good faith efforts.)*

☐ We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member, including *in loco parentis* relationships (as explained on page one). The information requested must be returned to us by _____ *(mm/dd/yyyy).* You may choose to provide a simple statement of the relationship or provide documentation such as a child's birth certificate, a court document, or documents regarding foster care or adoption-related activities. Official documents submitted for this purpose will be returned to you after examination.

☐ Other information needed *(e.g. documentation for military family leave)*: _____.

The information requested must be returned to us by _____ *(mm/dd/yyyy).*

If you have any questions, please contact: Donia Muturi, Global Benefits Administrator *(Name of employer representative)*

at dmuturi@meglobal.biz or 403-885-8553 *(Contact information).*

SECTION III – NOTICE OF RIGHTS AND RESPONSIBILITIES

Part A: FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to 12 weeks of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right

Employee Name: Chad Stallberg

under the FMLA to take up to 26 weeks of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as: *(Select as appropriate)*

- ☐ The calendar year (January 1st - December 31st)
- ☐ A fixed leave year based on _____
  (e.g., a fiscal year beginning on July 1 and ending on June 30)
- ☐ The 12-month period measured forward from the date of your first FMLA leave usage.
- ■ A "rolling" 12-month period measured backward from the date of any FMLA leave usage. *(Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.)*

If applicable, the single 12-month period for *Military Caregiver Leave* started on _____ *(mm/dd/yyyy)*.

You (■ are / ☐ are not) considered a key employee as defined under the FMLA. Your FMLA leave cannot be denied for this reason; however, we may not restore you to employment following FMLA leave if such restoration will cause substantial and grievous economic injury to us.

We (☐ have / ■ have not) determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. Additional information will be provided separately concerning your status as key employee and restoration.

Part B: Substitution of Paid Leave – When Paid Leave is Used at the Same Time as FMLA Leave

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

(Check all that apply)

- ☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **You have requested to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ■ **Other:** *(e.g., short- or long-term disability, workers' compensation, state medical leave law, etc.)* personal illness or paid m
  Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

The applicable conditions for use of paid leave include: return of health certification form.

For more information about conditions applicable to sick/vacation/other paid leave usage please refer to _____
Family Medical leave policy available at: MEGlobal Intranet HR US page.

Employee Name: Chad Stallberg

Part C: Maintain Health Benefits

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums. To make arrangements to continue to make your share of the premium payments on your health insurance while you are on any unpaid FMLA leave, contact NA at _____.

You have a minimum grace period of (☐ 30-days or ☐ NA *indicate longer period, if applicable)* in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following unpaid FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

Part D: Other Employee Benefits

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began. To make arrangements to continue your employee benefits while you are on FMLA leave, contact NA at _____.

Part E: Return-to-Work Requirements

You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

Part F: Other Requirements While on FMLA Leave

While on leave you (■ will be / ☐ will not be) required to furnish us with periodic reports of your status and intent to return to work every week.

(Indicate interval of periodic reports, as appropriate for the FMLA leave situation).

If the circumstances of your leave change and you are able to return to work earlier than expected, you will be required to notify us at least two workdays prior to the date you intend to report for work.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments, regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. EMPLOYEE INFORMATION.

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WHD
WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I: EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.**

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: Chad (First) _____ (Middle) Stallberg (Last)

(2) Employer name: MEGlobal Americas Inc. Date: 11/28/2023 (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by 12/22/2023 (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: Operations Technician Job description ☐ is / ☒ is not attached.

Employee's regular work schedule: 9/80

Statement of the employee's essential job functions:
Operates assigned equipment or areas of the plant and performs operations related activities as per Master Task List. Utilizes the knowledge and experience, to operate the plant in a safe and optimal manner.

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II: HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: Chad Stallberg

Health Care Provider's name: (Print) Frank J. Hoffmann MD

Health Care Provider's business address: 201 Oak Dr. So Suite 104 Lewisville, Tx 75067

Type of practice / Medical specialty: orthopedics

Telephone: 979-297-3004 Fax: 979297-3833 E-mail:

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: 12/7/23 (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: 12/7/23 - 12/18/23

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

☑ **Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☑ is expected to be) incapacitated for more than three consecutive, full calendar days from: 12/7/23 (mm/dd/yyyy) to 12/18/23 (mm/dd/yyyy).

The patient (☑ was / ☐ will be) seen on the following date(s): 10/16/23, 10/30/23, 11/9/23, 12/13/23, 12/27/23

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: Chad Stallberg

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

12/7/23 Arthroscopy Right knee per WCM 12/7/23-12/18/23
Starting 12/18/23
NO Bending, squatting, pushing, pulling, lifting, climbing ladders, excessive walking/standing over 20lbs

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☑ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): 10/16/23, 10/30/23, 11/9/23 12/18/23 12/27/23

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date 12/7/23 (mm/dd/yyyy) and end date 12/18/23 (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

Office Visits 1 q 2-3 Wks until released.

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule.**

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

(8) Due to the condition, the patient (☐ was / ☑ will be) **incapacitated for a continuous period of time,** including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date 12/7/23 (mm/dd/yyyy) and end date 12/18/23 (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☑ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur 1 time q 2-3 weeks times per (☐ day ☐ week ☑ month) and are likely to last approximately 2 hours (☐ hours ☐ days) per episode.

Employee Name: Chad Stallberg

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☑ is not able / ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

No Bending, Squatting, Pushing, Pulling, Lifting, Climbing Ladders, excessive walking / Standing

Signature of Health Care Provider _____ Date: 12/13/23 (mm/dd/yyyy)

Definitions and Requirements for Serious Health Condition

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following):

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

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

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

Employee Name: Chad Stallberg

Health Care Provider's name: (Print) Frank G. Hofmann MD

Health Care Provider's business address: 201 Oak Dr. So Suite 104 Lewisville, Tx 75067

Type of practice / Medical specialty: orthopedics

Telephone: 979-297-3004 Fax: 979297-3833 E-mail:

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: 12/7/23 (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: 12/7/23 - 12/18/23

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

☑ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☑ is expected to be) incapacitated for more than three consecutive, full calendar days from: 12/7/23 (mm/dd/yyyy) to 12/18/23 (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): 10/16/23, 10/30/23, 11/9/23, 12/13/23, 12/27/23

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: Chad Stallberg

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

12/7/23 Arthroscopy Right knee OPS WORK 12/7/23-12/18/23
Starting 12/18/23
No Kneeling, squatting, pushing, pulling, lifting, climbing ladders, excessive walking/standing over 20lbs

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(5) Due to the condition, the patient (☐ had / ☑ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): 10/16/23, 10/30/23, 11/9/23 12/13/23 12/27/23

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date 12/7/23 (mm/dd/yyyy) and end date 12/18/23 (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

Office Visits 1 q 2-3 wks until released.

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule.**

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

(8) Due to the condition, the patient (☐ was / ☑ will be) **Incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date 12/7/23 (mm/dd/yyyy) and end date 12/18/23 (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☑ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur 1 time q 2-3 weeks times per (☐ day ☐ week ☑ month) and are likely to last approximately 2 hours (☐ hours ☐ days) per episode.

Employee Name: Chad Stallberg

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☑ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

No Pushing, Squatting, Pushing, Pulling, Lifting, Climbing Ladders, excessive walking / Standing.

Signature of Health Care Provider _____ Date: 12/13/23 (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

HOC

From: Stallberg C (Chad) MEG [stallbc@meglobal.biz]
Sent: Wednesday, November 29, 2023 10:52 AM
To: hoc@quikus.com
Subject: Emailing: Chad Stallberg MEGlobal_Employee_Health_Certification_Form_USA-SL Office- updated
Attachments: MEGlobal_Employee_Health_Certification_Form_USA-SL Office- updated.pdf

Please fill out Section 3, and email form back to me. I believe I was told I could return to work after a week with restrictions. I don't normally work weekends, so I am hoping to return to work by 12-18-23...but I am leaving that up to you guys. Please reach out to me (979-292-6529) if you have any questions.

Thanks,
Chad Stallberg

Your message is ready to be sent with the following file or link attachments:

MEGlobal_Employee_Health_Certification_Form_USA-SL Office- updated

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.

Employee Health Certification Form

Return completed form to Donia Muturi via email: dmuturi@meglobal.biz

This form is used to:
1. Determine an employee's eligibility to qualify for benefits under MEGlobal Americas Inc. **Paid Medical Leave Policy**, and
2. To assess fitness for duty and assist in return-to-work planning

1. Employee Information (To be completed by Employee) Note: If employee is unable to complete this section, HR may complete

Stallberg, Chad	2753	29/08/1974
Employee Name (Last, First)	**Employee ID #**	**Date of Birth: (DD/MM/YYYY)**

Work Site:	Oyster Creek	**Home or Cell Phone:**	979-292-6529	**Leader Name:**	Clay Hammontree
Department:	Operations	**Work Phone:**		**HR Contact:**	S. Bielamowicz

2. Absence Related to Injury / Illness & Release (To be completed by Employee)

First Date of Work Missed: (DD/MM/YYYY)	07/12/2023	**Injury/Illness Occurred On: (DD/MM/YYYY)**	12/10/2023

Anticipated Return to Work Date (if known): (DD/MM/YYYY) 12/18/23 — unknown

Injury/illness is work related? ☒ No ☐ Yes (MEGlobal HR and EHS must be immediately notified of the injury/illness)

Release of Medical Records: I authorize the release of my Healthcare Provider's diagnosis/disposition, specific to this injury / illness, to MEGlobal Americas, its insurance carrier and/or All American Screening & Medical to assist with facilitating this medical leave. I certify the information I provided is accurate and complete to the best of my knowledge.

Employee Signature: [signature] **Date: (DD/MM/YYYY)** 01/12/2023

3. To be completed by Employee's Healthcare Provider
Provider Instructions: Complete the appropriate response and return to MEGlobal Human Resources

Medical Condition: (diagnosis, surgery type, etc.) Meniscus tear Right Knee
Arthroscopy Right Knee 12/7/23

Work status and anticipated duration:
- ☐ Full Work Release (no work restrictions)
- ☑ Restricted Work (listed below) starting 12/18/23
- ☑ No Work Until Further Notice
- ☐ Hospitalized or Referred for Additional Evaluation/Treatment

Restrictions: (Check all that apply and provide details below for any YES) Off work 12/7/23 - 12/18/23

Estimated duration of limitation(s): (DD/MM/YYYY)

☐ No ☑ Yes - Standing limited		☐ No ☐ Yes - Working Around Motorized Equipment / Machinery	
☐ No ☐ Yes - Upper Extremity Repetitive Motion: R L		☐ No ☑ Yes - Repeated Squatting or Bending none	
☐ No ☑ Yes - Walking limited		☐ No ☐ Yes - Vehicle Operation (includes any motorized equipment)	
☐ No ☑ Yes - Climbing Stairs / Ladders no ladders		☐ No ☑ Yes - Working at Heights none	
☐ No ☑ Yes - Lifting limited to 20 lbs.		☐ No ☐ Yes - Work In Areas with Dust, Fumes or Chemicals	
☐ No ☑ Yes - Strenuous Activities / Heavy Exertion none		☐ No ☐ Yes - Overtime Work Hours	
☐ No ☐ Yes - Overhead Work with Arms		☐ No ☐ Yes - Limited Work Hours	
☐ No ☐ Yes - High Dexterity Tasks with Hands		☐ No ☐ Yes - Other Restriction(s)	

Details of Limitations: (all YES's) No kneeling, squatting, pushing, pulling, lifting over 20lbs climbing ladders, excessive walking/standing

This condition is: ☑ Acute ☐ Chronic ☐ Pregnancy

12/18/23 - 1/18/24 all restrictions above

The likely duration and frequency of episodes of condition: 12/7/23 - 12/18/23 off work

Healthcare Provider Name & Address:	201 Oak Dr. So Suite 104 Lake Jackson, TX 77566		
Telephone #: 979 297 3004		[signature] Healthcare Provider Signature	12/13/23 Date (DD/MM/YYYY)

Notice of Eligibility & Rights and Responsibilities under the Family and Medical Leave Act

U.S. Department of Labor Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND TO THE DEPARTMENT OF LABOR. PROVIDE TO EMPLOYEE.

OMB Control Number: 1235-0003
Expires: 6/30/2026

In general, to be eligible to take leave under the Family and Medical Leave Act (FMLA), an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. §§ 825.300(b), (c) which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Date: 11/28/23 *(mm/dd/yyyy)*

From: MEGlobal Americas Inc. *(Employer)* To: Chad Stallberg *(Employee)*

On 11/27/23 *(mm/dd/yyyy)*, we learned that you need leave *(beginning on)* 12/07/23 *(mm/dd/yyyy)* for one of the following reasons: *(Select as appropriate)*

- ☐ The birth of a child, or placement of a child with you for adoption or foster care, and to bond with the newborn or newly-placed child
- ■ Your own serious health condition
- ☐ You are needed to care for your family member due to a serious health condition. Your family member is your:
  - ☐ Spouse ☐ Parent ☐ Child under age 18 ☐ Child 18 years or older and incapable of self-care because of a mental or physical disability
- ☐ A qualifying exigency arising out of the fact that your family member is on covered active duty or has been notified of an impending call or order to covered active duty status. Your family member on covered active duty is your:
  - ☐ Spouse ☐ Parent ☐ Child of any age
- ☐ You are needed to care for your family member who is a covered servicemember with a serious injury or illness. You are the servicemember's:
  - ☐ Spouse ☐ Parent ☐ Child ☐ Next of kin

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. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

SECTION I – NOTICE OF ELIGIBILITY

This Notice is to inform you that you are:

- ■ **Eligible** for FMLA leave. *(See Section II for any Additional Information Needed and Section III for information on your Rights and Responsibilities.)*
- ☐ **Not eligible** for FMLA leave because: *(Only one reason need be checked)*
  - ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately: _____ towards this requirement. *(months)*
  - ☐ You have not met the FMLA's 1,250 hours of service requirement. As of the first date of requested leave, you will have worked approximately: _____ towards this requirement. *(hours of service)*

Employee Name: Chad Stallberg

☐ You are an airline flight crew employee and you have not met the special hours of service eligibility requirements for airline flight crew employees as of the first date of requested leave (i.e., worked or been paid for at least 60% of your applicable monthly guarantee, and worked or been paid for at least 504 duty hours.)

☐ You do not work at and/or report to a site with 50 or more employees within 75-miles as of the date of your request.

If you have any questions, please contact: _____ *(Name of employer representative)*

at _____ *(Contact information).*

SECTION II – ADDITIONAL INFORMATION NEEDED

As explained in Section I, you meet the eligibility requirements for taking FMLA leave. Please review the information below to determine if additional information is needed in order for us to determine whether your absence qualifies as FMLA leave. Once we obtain any additional information specified below we will inform you, **within 5 business days**, whether your leave will be designated as FMLA leave and count towards the FMLA leave you have available. **If complete and sufficient information is not provided in a timely manner, your leave may be denied.**

(Select as appropriate)

☐ No additional information requested. If no additional information requested, go to Section III.

☑ We request that the leave be supported by a certification, as identified below.

☑ Health Care Provider for the Employee ☐ Health Care Provider for the Employee's Family Member

☐ Qualifying Exigency ☐ Serious Illness or Injury *(Military Caregiver Leave)*

Selected certification form is ☐ attached / ☐ not attached.

If requested, medical certification must be returned by 12/22/23 *(mm/dd/yyyy) (Must allow at least 15 calendar days from the date the employer requested the employee to provide certification, unless it is not feasible despite the employee's diligent, good faith efforts.)*

☐ We request that you provide reasonable documentation or a statement to establish the relationship between you and your family member, including *in loco parentis* relationships (as explained on page one). The information requested must be returned to us by _____ *(mm/dd/yyyy).* You may choose to provide a simple statement of the relationship or provide documentation such as a child's birth certificate, a court document, or documents regarding foster care or adoption-related activities. Official documents submitted for this purpose will be returned to you after examination.

☐ Other information needed *(e.g. documentation for military family leave)*: _____.

The information requested must be returned to us by _____ *(mm/dd/yyyy).*

If you have any questions, please contact: Donia Muturi, Global Benefits Administrator *(Name of employer representative)*

at dmuturi@meglobal.biz or 403-885-8553 *(Contact information).*

SECTION III – NOTICE OF RIGHTS AND RESPONSIBILITIES

Part A: FMLA Leave Entitlement

You have a right under the FMLA to take unpaid, job-protected FMLA leave in a 12-month period for certain family and medical reasons, including up to **12 weeks** of unpaid leave in a 12-month period for the birth of a child or placement of a child for adoption or foster care, for leave related to your own or a family member's serious health condition, or for certain qualifying exigencies related to the deployment of a military member to covered active duty. You also have a right

Employee Name: Chad Stallberg

under the FMLA to take up to **26 weeks** of unpaid, job-protected FMLA leave in a single 12-month period to care for a covered servicemember with a serious injury or illness (*Military Caregiver Leave*).

The 12-month period for FMLA leave is calculated as: *(Select as appropriate)*

- ☐ The calendar year (January 1st - December 31st)
- ☐ A fixed leave year based on _____
  (e.g., a fiscal year beginning on July 1 and ending on June 30)
- ☐ The 12-month period measured forward from the date of your first FMLA leave usage.
- ■ A "rolling" 12-month period measured backward from the date of any FMLA leave usage. *(Each time an employee takes FMLA leave, the remaining leave is the balance of the 12 weeks not used during the 12 months immediately before the FMLA leave is to start.)*

If applicable, the single 12-month period for *Military Caregiver Leave* started on _____ *(mm/dd/yyyy)*.

You (■ are / ☐ are not) considered a key employee as defined under the FMLA. Your FMLA leave cannot be denied for this reason; however, we may not restore you to employment following FMLA leave if such restoration will cause substantial and grievous economic injury to us.

We (☐ have / ■ have not) determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. Additional information will be provided separately concerning your status as key employee and restoration.

Part B: Substitution of Paid Leave – When Paid Leave is Used at the Same Time as FMLA Leave

You have a right under the FMLA to request that your accrued paid leave be substituted for your FMLA leave. This means that you can request that your accrued paid leave run concurrently with some or all of your unpaid FMLA leave, provided you meet any applicable requirements of our leave policy. Concurrent leave use means the absence will count against both the designated paid leave and unpaid FMLA leave at the same time. If you do not meet the requirements for taking paid leave, you remain entitled to take available unpaid FMLA leave in the applicable 12-month period. Even if you do not request it, the FMLA allows us to require you to use your available sick, vacation, or other paid leave during your FMLA absence.

(Check all that apply)

- ☐ **Some or all of your FMLA leave will not be paid.** Any unpaid FMLA leave taken will be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **You have requested to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ☐ **We are requiring you to use some or all of your available paid leave** *(e.g., sick, vacation, PTO)* during your FMLA leave. Any paid leave taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.
- ■ **Other:** *(e.g., short- or long-term disability, workers' compensation, state medical leave law, etc.)* personal illness or paid m
  Any time taken for this reason will also be designated as FMLA leave and counted against the amount of FMLA leave you have available to use in the applicable 12-month period.

The applicable conditions for use of paid leave include: return of health certification form.

For more information about conditions applicable to sick/vacation/other paid leave usage please refer to _____ Family Medical leave policy available at: MEGlobal Intranet HR US page.

Employee Name: Chad Stallberg

Part C: Maintain Health Benefits

Your health benefits must be maintained during any period of FMLA leave under the same conditions as if you continued to work. During any paid portion of FMLA leave, your share of any premiums will be paid by the method normally used during any paid leave. During any unpaid portion of FMLA leave, you must continue to make any normal contributions to the cost of the health insurance premiums. To make arrangements to continue to make your share of the premium payments on your health insurance while you are on any unpaid FMLA leave, contact NA at _____.

You have a minimum grace period of (☐ 30-days or ☐ NA *indicate longer period, if applicable)* in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

You may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave if you do not return to work following **unpaid** FMLA leave for a reason other than: the continuation, recurrence, or onset of your or your family member's serious health condition which would entitle you to FMLA leave; or the continuation, recurrence, or onset of a covered servicemember' s serious injury or illness which would entitle you to FMLA leave; or other circumstances beyond your control.

Part D: Other Employee Benefits

Upon your return from FMLA leave, your other employee benefits, such as pensions or life insurance, must be resumed in the same manner and at the same levels as provided when your FMLA leave began. To make arrangements to continue your employee benefits while you are on FMLA leave, contact NA at _____.

Part E: Return-to-Work Requirements

You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. An equivalent position is one that is virtually identical to your former position in terms of pay, benefits, and working conditions. At the end of your FMLA leave, all benefits must also be resumed in the same manner and at the same level provided when the leave began. You do not have return-to-work rights under the FMLA if you need leave beyond the amount of FMLA leave you have available to use.

Part F: Other Requirements While on FMLA Leave

While on leave you (■ will be / ☐ will not be) required to furnish us with periodic reports of your status and intent to return to work every week.

(Indicate interval of periodic reports, as appropriate for the FMLA leave situation).

If the circumstances of your leave change and you are able to return to work earlier than expected, you will be required to notify us at least two workdays prior to the date you intend to report for work.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THE DEPARTMENT OF LABOR. EMPLOYEE INFORMATION.

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you may **not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: Chad (First) _____ (Middle) Stallberg (Last)

(2) Employer name: MEGlobal Americas Inc. Date: 11/28/2023 (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by 12/22/2023 (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: Operations Technician Job description ☐ is / ☒ is not attached.

Employee's regular work schedule: 9/80

Statement of the employee's essential job functions:
Operates assigned equipment or areas of the plant and performs operations related activities as per Master Task List. Utilizes the knowledge and experience, to operate the plant in a safe and optimal manner.

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

ProActive WORK HEALTH SERVICES

Brazosport Front Desk <brazosfrontdesk@proactivework.com>

FAX SUCCESS TO 19792973833

1 message

faxreturn <faxreturn@masergy.com> Fri, Dec 15, 2023 at 9:44 AM
Reply-To: faxreturn@masergy.com
To: brazosfrontdesk@proactivework.com

Dear ProActive FAX,

The following are the results for Fax Subject:001fc11f23a4-BrdLCdB-B0D8405FF0EC415DAFAEDB800CF100E5

MessageID	: 84275628
Creation Time	: 12/15/2023 7:40:49 AM
Dialed Number	: 19792973833
Pages Sent	: 3
Fax Status	: SUCCESS
Country	: USA
Duration	: 2:48

Thank you for using Masergy Virtual Fax Solution.

If you have any comments on our service, please contact us at:

ucsupport@masergy.com

ProActive
WORK HEALTH SERVICES

1100 North Brazosport Blvd. Ste. 3
Freeport, TX 77541

P: 979-705-7565
F: 979-358-3010

Contact: Lydiann Harmon, lharmon@proactiveworks.net

FAX

DATE: 12/15/2023	**TO:** Hoffman Orthopedics
PHONE: 979 297 3004	**FAX:** 979 297 3833

FROM:	
☐ *Steven Seefeldt, M.D.*	☒ *Ralph Wehmer, M.D.*

SUBJECT: Release of medical records.

NOTES:

MEGlobal
An EQUATE Company

Employee Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: Chad Stallberg Date of Birth: Aug 29, 1974

The information you may release subject to this signed release form is as follows:

☒Complete Records	☐History & Physical	☐ Progress Notes
☐Care Plan	☐ Lab Reports	☐ Radiology Reports
☐Pathology Reports	☐ Treatment Record	☐ Operative Reports
☐Hospital Reports	☐ Medication Record	☐ Other (please specify)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: ProActive Work Health Services
Address: 1100 N Brazosport Blvd, Suite 3
Freeport, TX 77541
Email: dpatterson@proactiveworks.net
Fax: 1-979-239-3002

The purpose/reason for this release of information is as follows:

_____

_____

_____

Signature:
Dec 13, 2023
Date

450 93 9291
Social Security Number

Chad A. Stallberg
Print Name of Patient

Print name of Witness

Signature of Patient

Signature of Witness

T + 1 844 634 5529
www.meglobal.biz
MEGlobal Americas Inc.
2150 Town Square Place
Seventh Floor, Suite 750
Sugar Land, TX 77479
USA

ProActive
WORK HEALTH SERVICES

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I Chad A. Stallberg (Patient's Name) hereby authorize Hoffman Orthopedics to release my protected health information regarding medical history, injury or illness, consultation, prescriptions, treatment, diagnosis, prognosis, including all diagnostic and laboratory results, correspondence and medical records including those from my other healthcare providers that the above-named healthcare provider may hold to:

Name: PROACTIVE WORKS
Address: 1100 N BRAZOSPORT #3 City: FREEPORT State: TX Zip: 77541
Phone: 9797057565 Fax: 9793583010
Email: BRAZOSFRONTDESK@PROACTIVEWORKS.NET ~~.NET~~ .com

This disclosure records will be used for the following purpose: _____

The authorization is:
[X] Unlimited (all records excluding addiction medicine and mental health treatment, and HIV test results
[ ] Limited to the following: _____

I also authorize the specific release of the following records:
Addiction Medicine Treatment _____(initial) Psychiatric/Mental Health Treatment _____(initial)
Test for antibodies to HIV _____(initial) Genetic Information _____(initial)

DURATION: This authorization shall remain in effect until _____ (date)
REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit listed for your region of service on the reverse side of this form. Your cancellation will not affect information that was released prior to receipt of the written request.
RESTRICTIONS: Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless another disclosure specifically required or permitted by law.

A Photocopy of facsimile of this authorization is considered as effective and valid as original.

I have been advised of my right to receive a copy of this authorization.

[signature] Self
Signature of patient or legal guardian **Relationship *if other than patient***

Chad A. Stallberg 12-15-23
Patient's Name (PRINT) **Date**

Aug 29, 1974
Patient's Date of Birth