som\_currentexportedda

som\_contactname

address1\_line1 address1\_line2

address1\_city, address1\_stateorprovince address1\_postalcode

|  |  |  |  |
| --- | --- | --- | --- |
| Re: Employee ID#: som\_eid | Leave type: | | **Non-FMLA som\_leavetype** |
|  | |  | **With Extended Use of Leave Credits** |

Dear fullname:

Your request for extended use of leave credits for a som\_leavetype leave of absence has been som\_requestapprovaltype under the applicable Civil Service Rule or collective bargaining agreement.

|  |  |  |
| --- | --- | --- |
| Leave Start Date: | Leave End Date: | Return-to-Work Date: |
| som\_leavestartdate | som\_leaveenddate | som\_estimatedrtwdate |

Your leave does not meet the requirement for FMLA due to the following reason:

**som\_leavedenialreason1name**

**som\_leavedenialreason2name**

You have indicated your leave credits be used as follows:

|  |  |  |
| --- | --- | --- |
| **Leave credits** | **Use all/Freeze all/Only Freeze This Amount/No Credits** | **amount to freeze** |
| Annual Leave | som\_annualleavecreditusage | som\_annualleavefreezeamount |
| Banked Leave | som\_bankedleavecreditusage | som\_bankedleavefreezeamount |
| Deferred Hours | som\_deferredhourscreditusage | som\_deferredhousesfreezeamount |
| Comp Time | som\_comptimecreditusage | som\_comptimefreezeamount |
| Sick Leave | som\_sickleavecreditusage | som\_sickleavefreezeamount |
| Other: | som\_othercreditusage | som\_otheramountleavefreezeamount |

To extend your leave:

* You must submit a written statement, from the treating physician, indicating the reasons for the extension and the new return-to-work date. This can be written on physicians’ letterhead or Rx script.
* The statement must be received by the DMO five days prior to your leave end date.
* It remains your responsibility to inform your supervisor of your new return-to-work date.

Returning to work:

If you are off work on a personal medical leave, prior to returning to work, a physician statement permitting you to return, with or without restrictions. The statement must be received five days before the leave end date and must be signed and dated by the physician within 14 days of the return date.

Note: Your Physician Statement status is: **som\_physicianstatement**

* Restriction statements must indicate the physical limitations and the duration. The DMO will work with you and your agency to evaluate if your essential job functions are compatible with any work restrictions. Restrictions must be approved before returning to work.
* You must contact the DMO on your first day back to work to update your leave status.
* If a physician statement is not received by the DMO before your leave expires, you may be considered absent without leave and subject to discipline, up to and including separation, for an unauthorized leave of absence.

Submit documentation to:

DMO  
P.O. Box 30002  
Lansing, Michigan 48909  
Fax 517-241-9926  
\*Email: [MCSC-DMO@michigan.gov](mailto:MCSC-DMO@michigan.gov)

*\*By choosing to email documentation, you accept the risks that unencrypted messages and any attachments can be intercepted, read, and copied by persons other than the intended recipient.*

If you have any questions regarding this determination, your rights and responsibilities, or any certifications or forms that you must still provide, contact the DMO at 877-443-6362, Option 2.

Sincerely,

owneridname

Disability Management Office

cc: som\_supervisorname, Supervisor