som\_currentexporteddate

som\_contactname

address1\_line1

address1\_city, address1\_stateorprovince address1\_postalcode

|  |  |  |  |
| --- | --- | --- | --- |
| Re: Employee ID#: som\_eid | Leave type: | | **LoA - Family Care or Military Caregiver Leave or Leave Extension - FMLA** |
|  | |  |  |

Dear fullname:

Your request for an FMLA LoA - Family Care or Military Caregiver Leave or Leave Extension – FMLA or Leave extension is approved. Your FMLA entitlement will run concurrently with your leave of absence until your entitlement is exhausted.

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

If your anticipated leave schedule does not change, som\_fmlahours hours will count against your FMLA entitlement.

You have requested that 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 |

If you exhaust your sick leave credits and are not using other leave credits:

* You will be taken off payroll.
* If eligible, an Application to Continue Insurances (CS-1820) will be mailed to you and must be returned to Employee Benefits Division (EBD).
* You are responsible for payment arrangements on any other payroll deductions that remain active while on unpaid leave (Friend of the Court, 401k loans, garnishments, levies, etc.).

If you cannot return to work on the date indicated above, a statement from the som\_patientcarefamilycareonly health care provider must be submitted at least five days before the leave end date. The statement must indicate reasons for the extension and the new expected return-to-work date. It is your responsibility to inform your supervisor of your new return-to-work date.

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.*

The DMO may request that you provide an updated physician’s statement relating to your som\_patientcarefamilycareonly serious health condition every six months up to the expiration of your leave end date.

Please be advised that if the Serious Health Condition of your som\_patientcarefamilycareonly no longer exists or care is no longer necessary (i.e. recovery, passing, etc.) prior tosom\_patientcarestartdate, your Family Care leave approval will expire at that time and your claim will be closed.

You will not be required to present a fitness-for-duty certificate before being restored to employment.

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