som\_currentexportedda

som\_contactname

address1\_line1 address1\_line2

address1\_city, address1\_stateorprovince address1\_postalcode

|  |  |  |
| --- | --- | --- |
| Re: Employee ID#: som\_eid | Leave type: | **FMLA Intermittent Leave** |
|  |  | **som\_leavetype** |

Dear fullname:

The Disability Management Office (DMO) is in receipt of documentation for time off work for an FMLA Intermittent leave .

You currently have som\_fmlahours FMLA entitlement hours available. At this time, it is not possible to calculate how much leave will count against your FMLA entitlement.

The DMO has approved request. See details below.

**APPOINTMENTS**

|  |  |  |
| --- | --- | --- |
| **som\_appointments** | **Start Date**: som\_appointmentsstartdate | **End Date**: som\_appointmentsenddate |
| **Frequency**: som\_appointmentsfrequency som\_appointmentsfrequencytype | **Duration**: som\_datesofscheduledappointments | |
|  | | |
|  | | |

**EPISODES**

|  |  |  |
| --- | --- | --- |
| **som\_episodes** | **Start Date**: som\_episodesstartdate | **End Date**: som\_episodesenddate |
| **Frequency**: som\_episodesfrequency som\_episodesfrequencytype | **Duration**: som\_episodesduration som\_episodesdurationtype | |
|  | | |
|  | | |

**PATIENT CARE (Family Care only)**

|  |  |  |
| --- | --- | --- |
| **som\_patientcarefamilycareonly** | **Start Date**: som\_patientcarestartdate | **End Date**: som\_patientcareenddate |
| **Frequency**: som\_patientcarefrequency som\_patientcarefrequencytype | **Duration**: som\_patientcareduration som\_patientcaredurationtype | |
|  | | |

**REDUCED WORK SCHEDULE**

|  |  |  |
| --- | --- | --- |
| **som\_reducedworkschedule** | **Start Date**: som\_reducedworkschedulestartdate | **End Date**: som\_reducedworkscheduleenddate |
| **Frequency**: som\_reducedworkschedulefrequencyhoursperday | **Duration**: som\_reducedworkscheduledurationdaysperweek | |
|  | | |

**\*Insufficient documentation, as indicated above, must be updated by the health care provider and received in the DMO** by**:** **[Enter date or N/A]**. Any updates must be initialed and dated by the health care provider.

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

Sincerely,

owneridname

Disability Management Office

cc: som\_supervisorname, Supervisor