som\_currentexportedda

som\_contactname

address1\_line1 address1\_line2

address1\_city, address1\_stateorprovince address1\_postalcode

|  |  |  |  |
| --- | --- | --- | --- |
| Re: Employee ID#: som\_eid | Leave type: | | **Non-FMLA** |
|  | |  | **UAW Family Care Leave** |

Dear fullname:

Your request for family care leave is som\_requestapprovaltype according to the UAW collective bargaining agreement, Article 50, Section B:

*Eligibility  
After the completion of 1040 hours of satisfactory service an employee, upon depletion of accrued sick leave and upon written employee request, and in accordance with this Section, will be granted, once during his/her employment, an unpaid leave of absence including necessary extensions for a period not to exceed three (3) months to care for the employee's seriously ill or seriously injured spouse, child or parent who is dependent on the employee for care and support…*

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

If you cannot return to work on the date indicated above, a statement from the family member’s 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.*

You may be required to furnish an updated physician’s statement relating to your family member’s serious health condition upon request.

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