Disability Management Unit

VERIFICATION OF DELIVERY

Patient Name: _____

Patient DOB: _____

Employee ID#: _____

This information is being requested to process our employee's request for maternity leave.

****PLEASE COMPLETE****

DELIVERY TYPE:	(Check one) ☐ Vaginal Delivery ☐ Cesarean Section
DELIVERY DATE:	
POSTPARTUM APPOINTMENT DATE:	
PHYSICIAN SIGNATURE:	
DATE:	
HEALTH CARE PROVIDER NAME:	
ADDRESS:	
PHONE NUMBER:	

Please return the completed verification to the Disability Management Unit at:

Fax: 517-241-6898

Disability Management Unit
PO BOX 30003
Lansing, Michigan 48909
Phone: 877-443-6362
www.michigan.gov/dmu