Disability Management Office (DMO)
State of Michigan
Phone: 877-443-6362, option 2

VERIFICATION OF DELIVERY

Employee information:

Patient/Employee name:	Employee ID#:	Patient date of birth:

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

To be completed by health care provider:

Delivery type: (check one)	☐ Vaginal delivery ☐ Cesarean section
Delivery date:	(provide date)
Postpartum appointment date:	(provide date)

Health care provider name and business address:

Name:	
Address:	
Type of practice/medical specialty:	
Phone number:	
Fax number:	

Signature of health care provider:	
Date:	

Return completed form to:
Fax: 517-241-9926
Email: MCSC-DMO@michigan.gov