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

FAMILY CARE LEAVE EXTENSION

To be completed by employee:

Employee name:	
Employee ID#:	
Family member's name:	
Relationship to employee: (check one)	☐ Spouse ☐ Parent ☐ Child

The below information is required for our employee to extend their current Family Care leave of absence.

To be completed by health care provider:

Employee's new estimated return to work date:	(provide date)
Provide a diagnosis and/or any medical facts, symptoms, regimen of treatment, related to patient's condition.	

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: 517-284-9951
Email: MCSC-DMO@michigan.gov