SAMPLE - Approval of Medical Leave of Absence Without Pay

[Date]

[Name]
[Address]

Via **[Hand Delivery OR Certified Mail No._____]**

Dear **[Mr./Ms. Last Name]**:

The purpose of this letter is to acknowledge receipt of your physician's statement (Form DOP-L3) and your request for a medical leave of absence from your position as **[classification]** dated **[date]** that you submitted to **[name]**, **[title]**.

In accordance with the West Virginia Division of Personnel *Administrative Rule*, W. VA. CODE R. §143-1-14, an employee is entitled to a medical leave of absence without pay not to exceed six (6) months within a twelve month period provided:

[Insert MLOA language from current *Administrative Rule*]

Your request for a medical leave of absence for the period beginning **[date]**, **[time]**, through **[date]**, **[time]**, has been approved. You are expected to return to duty on **[date]** at your regularly scheduled work time of **[time]**. Although the federal Family and Medical Leave Act (FMLA) provides for up to twelve (12) weeks of unpaid leave for an employee's own serious health condition, the *Administrative Rule* provides a more generous medical leave benefit of up to six (6) months and therefore, exhausts any entitlement provisions of this federal law. Any unpaid leave granted under the provisions of 14.8.c. will count against and run concurrently with any entitlement you may have under FMLA. A Designation Notice (Form DOP-L10) is enclosed.

For your information, subsection 14.8.d. of the *Administrative Rule*, which sets forth an employee's responsibility at the end of a leave of absence without pay, is enclosed with this letter. Also enclosed is an Application to Receive Donated Leave **[*If applicable*]**. For more information, you may wish to visit the Division of Personnel's website at www.state.wv.us/admin/personnel/.

During your period of absence, it is imperative that you contact **[name]**, **[title]**, at **[telephone number]** concerning any requirements that may be necessary for you to maintain your health and/or life insurance. Failure to submit payment of your premiums may result in cancellation of coverage. If you have any questions or need additional information, please contact **[name]**, **[title]**, at **[telephone number]**.

[*If appropriate*] During your leave of absence, you are restricted from all non-public areas of the **[office name(s)]** with the exception of **[office name(s) (e.g., supervisor/manager/human resources office)]**. If it is necessary for you to come to **[office name(s)]**, an appointment must be arranged in advance and **[name]**, **[title]**, will meet you in the lobby. You may arrange such an appointment by contacting **[name]**, at **[telephone number]**. Further, you are not to remotely access the State's employee technology

resources (email, mainframe, etc.) or otherwise perform work for **[agency/department name]** **[*Agencies should not permit the employee to take agency-issued phones or IT equipment with them while on leave.*]**.

Sincerely,

[Appropriate Signature Authority]

Enclosures

c: Agency Personnel File
West Virginia Division of Personnel

[OPTIONAL LANGUAGE - *If the employer meets with the employee and hand delivers the letter, the employer may request that the employee verify receipt by signing the following acknowledgment typed at the bottom of the letter.*]

I have received a copy and am aware of the contents of the foregoing letter

_____ _____
Employee Signature Date

[OPTIONAL LANGUAGE - *If mailed via U. S. Postal Service, the following certification may be typed at the bottom of the letter.*]

The undersigned certifies that the above letter / notification was mailed to **[name]** by first-class and certified mail, return receipt requested, on the _____day of _____, 20_____.

[signature]_____
[typed name and title]

[NOTE: *Revised 6/2013. Ensure law, rule, and policy language is current.*]