***<DATE>***

***<NAME>***

***<ADDRESS>***

Dear ***<NAME>***,

The Department is in receipt of your medical certification dated ***<MED. CERT. DATE>***. Your medical leave extension has been approved from ***<START DATE>*** to ***<END DATE>***. If any changes to your leave return date occur, please provide ***<XX>*** days notice and a new medical certification. The Department will notify you if you need to provide a return to work certification 15 days prior to returning to work.

If you have any questions about your leave, please contact me at ***<565-xxxx>*** or ***<Analyst Name, Disability Management Analyst>*** at ***<565-xxxx>***. More information and copies of the Medical Leave Policy, Disability and Reasonable Accommodation Policy, and the Temporary Transitional Duty Policy, can be found at:
<https://sonomacounty.ca.gov/HR/Disability-Management/Policies/>

Sincerely,

***<Dept Designee>***

cc: ***<DM Analyst Name>***, Disability Management Analyst

 Confidential Medical File