

SAMPLE – MLOA Denial - Permanent Disability

[An agency could also dismiss without giving the opportunity to return since the employee has provided information that they cannot perform the job functions.]

[Date]

[Name]

[Address]

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

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

The purpose of this letter is to determine your intentions regarding your employment as a **[classification]** with the **[agency/department name]**. You have been continuously absent from work since **[date]**, and had sufficient sick leave and annual leave used in lieu of sick leave for you to remain on the payroll through **[number]** hours on **[date]**. After expiring all accrued paid leave, you were granted a medical leave of absence without pay commencing on **[date]** through **[date]**. This leave ran concurrently with your leave entitlement under the federal Family and Medical Leave Act (FMLA).

In accordance with subsection 14.8 of the Division of Personnel's *Administrative Rule*, W. VA. CODE R. §143-1-1 *et seq.*, Leave of Absence Without Pay, you are entitled to a medical leave of absence without pay not to exceed six (6) months within a twelve month period. Additionally, you may request a personal leave of absence without pay; however, approval of a personal leave of absence is at the discretion of the appointing authority.

On **[date]**, I received information provided by your physician that indicates that your condition will permanently prevent you from performing your duties as a **[classification]**. *[Include information regarding unsuccessful interactive dialogue with the employee in trying to provide a reasonable accommodation.]* In accordance with subsection 14.8.c. of the *Administrative Rule*, we cannot approve a medical leave of absence without pay under those circumstances. Furthermore, a discretionary personal leave of absence will not be approved due to **[reasons – e.g., agency work need, financial reasons, etc.]**. 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.

On **[date]**, **[name]**, **[title]**, informed you that **[agency/department name]** cannot grant any type of additional leave of absence for you. At that time it was shared with you that your dismissal for failure to return from leave of absence was being considered. Your **[response was/responses were...]**.

Therefore, if you do not return to work, immediately providing Form DOP-L3 (enclosed), completed by your physician, and releasing you to return to full, unrestricted duty by **[date - provide at least 10 calendar days from date of letter]**, I must conclude that you are not returning to work at the expiration of your leave of absence without pay. In such case, this letter will serve as a fifteen calendar (15) day notification of your dismissal from the **[agency/department name]**, effective **[date – 15 calendar days from the date of the letter]**. This action would be taken in accordance with subsections 12.2 and 14.8 of the *Administrative Rule*. Should you not return, I must conclude that you have elected to be paid up to a maximum of fifteen (15) calendar days' severance pay instead of working out the notice period. You will also be paid for all annual leave accrued and unused as of your last working day with this agency.

Should such occur, all property belonging to the State of West Virginia, which you have under your control or in your personal possession, must be returned and delivered to the control of **[name]**, **[title]**, immediately or at a mutually agreed upon date, time, and location. Such property shall include, but not be limited to: keys to any State offices, access cards, and identification cards. You are not to enter the non-public areas of the **[agency/department name]** offices without prior authorization from me or an agent of my office.

You may respond to me, in person and/or in writing, concerning the contents of this letter, provided you do so within fifteen (15) calendar days of its date. Please contact my office at **[telephone number]** if you wish to schedule an appointment. Further, if you have reason to believe the information contained in this letter is inaccurate, then you may respond in writing, provided your response is postmarked within fifteen (15) calendar days of the date of this letter.

According to the provisions of W. VA. CODE §5-16-13(c), you may be eligible to continue insurance coverage for up to three months following your dismissal. Additionally, after expiring any coverage granted by State law, the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C. Sec. 1162, may provide for an additional period of coverage. You should contact the Public Employees Insurance Agency (PEIA), at (304) 558-7850 or 1-888-680-7342, for specific information concerning eligibility, coverage, and premium payment.

For any appeal rights you may have, please refer to W. VA. CODE §6C-2-1 *et seq.*, the West Virginia Public Employees Grievance Procedure. If you choose to exercise your grievance rights, you must submit your grievance, on the prescribed form, within fifteen (15) working days of the effective date of this action, to **[name and address of Chief Administrator]** at Level One of the Procedure. As provided in the statute, you may proceed to Level Three of the Procedure by filing your grievance directly with the Public Employees Grievance Board upon the agreement of the chief administrator, or when dismissed, suspended without pay, or demoted or reclassified resulting in a loss of compensation or benefits. You must provide copies of your grievance accordingly to the Public Employees Grievance Board at 1596 Kanawha Boulevard, East, Charleston, West Virginia, 25311; **[agency copy - name and address]**; and the Director of the Division of Personnel, Building 6, Room B-416, State Capitol Complex, Charleston, West Virginia, 25305. Details regarding the grievance procedure, as well as grievance forms, are available at the Board's web site at www.pegb.wv.gov or you may telephone the Board at (304) 558-3361 or toll-free at (866) 747-6743.

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 10/2014. Ensure law, rule, and policy language is current.]