DATE

NAME

ADDRESS

CITY STATE ZIP

Dear FIRSTNAME,

Your current Family Medical Leave (FMLA) #XXX will be exhausted on or about DATE. You are receiving this letter because you have indicated the need for an extended time off for medical reasons.

Iowa Administrative Code Chapter 11.63.5(4) provides for eight weeks of continuous leave to recover from a medically related disability. A request for this leave must be received in writing and contain verification from your medical provider, including any reasons that prevent you from performing your regular work duties. Once this leave begins, you may use up to eight weeks continuously but the time may not be used for intermittent leave. During the eight-week leave period, we may request a Health Care Provider’s (HCP) medical note to verify the need to continue the medical leave. If you want to maintain insurance coverage during the leave period, you are responsible for both the employee share and State of Iowa share of insurance premiums.

To request this leave, have your HCP complete the section below. The HCP’s signature verifies the leave is needed to recover from a medically related disability.  Please return the completed form to Human Resources no later than DATE.

Please let us know immediately if you are unable to provide verification by the date requested.

If you will be returning to work at the end of your Family Medical Leave, please provide a release to work notice from your HCP. Human Resources needs to receive the release before or on the first day you return to work.

In addition, I am including information and a claim form for Long Term Disability Insurance (LTD), the Benefit Guide, LTD Income Benefits Questionnaire (to be completed by employee), and Attending Physician’s Statement of Functionality (to be completed by HCP).

If your return to work status changes at any time, you must notify your supervisor.

Please contact me if you have questions.

Sincerely,

NAME

TITLE

PHONE

EMAIL

**Employee Request for 11 IAC 63.5(4) Leave**

I request to be placed in an approved leave status to recover from a medically related disability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee signature Date

**Medical Verification**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s name

I hereby verify the need for the above-named employee to be off work to recover from a medically related disability until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please enter date if known). The employee cannot perform the regularly assigned work duties because:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider signature Date