[Date]

Name

Address

Email address

Dear [name],

You are receiving this letter because you have indicated the need for time off to recover from a medical issue.

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 reason(s) that prevent you from performing your regular work duties. Additionally, if you apply for leave under the Family and Medical Leave Act, any leave without pay under the FMLA will run concurrently with this request (see Iowa Administrative Code Chapter 11.63.5(5)).

To request this leave, have your medical provider complete the section below. The medical provider’s signature verifies that the leave is to recover from a medically related disability. Please return the completed form to this office no later than \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

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

Please contact this office if you have questions.

Employee Request

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

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

Employee signature and date

**Medical Verification**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby verify the need for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be off work to

 Medical provider (please print) Employee’s name

 recover from a medically related disability until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The employee can

 Anticipated return date

not perform their regular work duties because:

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

Medical provider’s signature and date