Your Health Care Provider’s Letterhead

# [Date]

To whom it may concern:

I am the [treating physician, nurse practitioner, nurse midwife, licensed midwife, clinical psychologist, clinical social worker, licensed marriage or family therapist, licensed acupuncturist, physician assistant, chiropractor, social worker, or health care professional] for [Your Name].

[Your name] has a medical condition that limits major life activities, including [fill in relevant “major life activities,” such as: concentrating, thinking, interacting with others, communicating, performing manual tasks, walking, standing, lifting, bending, speaking, breathing, reading, seeing, hearing, sleeping, eating, and caring for oneself, or the operation of a major bodily function. “Working” should be listed only if no other activity applies].

As a result of this disability, **[*Your Name*]** is temporarily unable to work. **[*She/he*]** needs a leave of absence for treatment and recovery. This leave **[*began on [date]/is scheduled to begin on***

***[date*]**.

I anticipate that the employee will be able to return to work on **[*Your health care provider must provide a return-to-work date, even if it must be changed later – an “indefinite” leave of absence without a return-to-work date may not be considered a reasonable accommodation]****.*

Thank you.

**[Signature]**