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 <u>must</u> 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]