

[Current Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Subject: Request for Medical Certification for Short-Term Disability Leave

Dear [Employee Name],

We received your notification regarding your need for a leave of absence starting on [Leave Start Date] due to a personal medical condition. To process your request for Short-Term Disability (STD) benefits, we require formal medical certification from your healthcare provider.

Please find the attached Medical Certification Form. You must have your treating physician complete this form and return it to the [Human Resources Department / Benefits Office] no later than [Due Date - typically 15 days].

The required documentation must include:

- The date the condition commenced.
- The probable duration of the condition.
- Appropriate medical facts regarding the condition as it relates to your ability to perform your job functions.

Failure to provide the requested certification within the specified timeframe may result in a delay or denial of your Short-Term Disability benefit payments.

All medical information provided will be kept confidential and stored separately from your personnel file in accordance with privacy laws.

Please contact [Contact Name] at [Phone Number] or [Email Address] if you have any questions regarding this request.

Sincerely,

[Your Name]

[Your Title]

[Company Name]

Attachment: Medical Certification Form