

[Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Re: Denial of Short Term Disability Extension Request

Dear [Employee Name],

We have received and reviewed your request for an extension of your Short Term Disability (STD) leave, which was submitted on [Date Request Received].

After a thorough review of the medical documentation provided by your healthcare provider, we regret to inform you that your request for an extension has been denied. This decision was based on the following reason(s):

- [Insert specific reason, e.g., Insufficient medical evidence to support continued disability.]
- [Insert specific reason, e.g., The medical documentation does not meet the definition of disability under the company policy.]
- [Insert specific reason, e.g., Failure to provide updated records by the required deadline.]

As a result of this denial, your current Short Term Disability benefits will conclude on [Last Date of Approved Leave]. You are expected to return to work in your regular capacity on [Return to Work Date].

If you are unable to return to work on the date specified above, please contact [Department/Contact Person Name] at [Phone Number/Email] immediately to discuss any alternative leave options or potential accommodations that may be available under the Americans with Disabilities Act (ADA) or other applicable laws.

You have the right to appeal this decision. If you wish to appeal, you must submit a written request along with any additional supporting medical documentation to [Appeals Department Name/Address] by [Deadline Date].

Sincerely,

[Your Name]

[Your Title]

[Company Name]