[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Subject: Long-Term Disability (LTD) - Fitness for Duty Requirement

Dear [Employee Name],

Our records indicate that you have been receiving Long-Term Disability (LTD) benefits since [Date]. As part of your ongoing claim and in preparation for a potential return to the workplace, we require a formal "Fitness for Duty" evaluation.

To assess your current ability to perform the essential functions of your position, please have your treating physician complete the enclosed medical certification form. This documentation must address the following:

- Your current clinical status and functional limitations.
- Whether you can return to your regular position with or without restrictions.
- The specific nature and duration of any necessary workplace accommodations.
- An estimated date for a full, unrestricted return to duty.

Please submit the completed medical documentation to the Human Resources Department by [Deadline Date]. This information is necessary to determine your continued eligibility for benefits and to facilitate your transition back to work.

Failure to provide the requested documentation by the deadline may impact your LTD benefit status or your employment standing. If you or your physician have questions regarding your job description or the requirements of your role, please contact us immediately.

Please return the forms via [Email Address, Fax Number, or Mailing Address].

Sincerely,

[Your Name]
[Your Title]
[Company Name]

Enclosure: [Medical Certification Form / Job Description]