

[Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Subject: Conditional Approval of Short-Term Disability Leave

Dear [Employee Name],

We have received your request for a leave of absence for personal medical reasons starting on [Start Date]. We are writing to inform you that your request for Short-Term Disability (STD) leave is **conditionally approved** pending the receipt and review of the required medical documentation.

To finalize your leave and disability benefits, please ensure the following actions are completed:

- Submit the "Attending Physician Statement" to [Department/Insurance Provider Name] no later than [Due Date].
- Provide an estimated return-to-work date as determined by your healthcare provider.
- Keep your supervisor informed of any changes to your expected return date.

Please note that this conditional approval is based on the information currently available. If the required documentation is not received by the deadline, or if the medical information provided does not meet the plan's criteria for disability, your leave may be reclassified as unprotected or unpaid, and your claim may be denied.

While on leave, you are expected to comply with all company policies regarding leave of absence. If you have any questions regarding your benefits or the documentation required, please contact [Name/Department] at [Phone Number] or [Email Address].

We wish you a speedy recovery.

Sincerely,

[Sender Name]

[Sender Title]

[Company Name]