

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email]

[Date]

[Physician's Name or Clinic Name]
[Clinic Address]
[City, State, Zip Code]

RE: Request for FMLA Leave Extension Documentation for [Your Name]

Dear Dr. [Physician's Last Name],

I am writing to formally request the necessary medical documentation to support an extension of my current Family and Medical Leave Act (FMLA) leave. My current approved leave is scheduled to end on [Current End Date].

Due to my ongoing medical condition and based on our recent consultation on [Date of last visit], it has been determined that I am not yet able to return to work. I am requesting that my leave be extended until approximately [New Requested End Date] to allow for [mention reason, e.g., continued recovery, physical therapy, or medication adjustment].

Please provide an updated medical certification or a letter addressed to my employer, [Employer Name], that includes the following information:

- A statement confirming the continued need for medical leave.
- The updated expected duration of my incapacity.
- The anticipated date on which I may return to work.
- Any specific work restrictions or accommodations required upon my return, if known at this time.

My employer requires this documentation by [Deadline Date] to process the extension. Once the paperwork is ready, please [choose one: mail it to my home address / fax it to my employer at Fax Number / notify me for pickup].

Thank you for your continued care and for your assistance with this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Date of Birth]