

[Date]

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

Subject: Notification of FMLA Exhaustion and ADA Interactive Process

Dear [Employee Name],

We are writing to formally notify you that your leave under the Family and Medical Leave Act (FMLA) is scheduled to expire on [Date]. According to our records, you will have exhausted your 12-week entitlement as of that date.

As you approach the end of your protected leave, [Facility Name] remains committed to supporting your return to work. If you are unable to return to your position at full capacity on [Date] due to a medical condition, you may be eligible for a reasonable accommodation under the Americans with Disabilities Act (ADA).

To begin the interactive process and determine how we may assist you, please provide the following by [Deadline Date]:

- Updated medical certification regarding your current functional limitations.
- An estimated date for your return to work (with or without restrictions).
- Suggested accommodations that would enable you to perform the essential functions of your job.

Enclosed is a "Medical Provider Functional Capacity" form for your physician to complete. This information will help us evaluate whether further leave as an accommodation or a modified work assignment is feasible without causing undue hardship to the facility.

Please note that if we do not hear from you or receive the required medical documentation by [Deadline Date], we will proceed with employment decisions based on the information currently available, which may include the termination of your employment due to your inability to return to work at the conclusion of FMLA leave.

Please contact the Human Resources Department at [Phone Number] or [Email Address] to discuss your status or to submit your documentation.

Sincerely,

[Signature]
[Name of HR Representative]
[Title]
[Facility Name]

Enclosure: Medical Provider Functional Capacity Form