[Insert date]

[Insert employee name]
[Insert employee address]
[Insert city, state ZIP]

RE: Expiration of FMLA Leave

Dear [insert employee name],

As a reminder, your 12 weeks of approved leave under the Family and Medical Leave Act (FMLA) will expire on [insert date]. Accordingly, you are expected to return to work on [insert date]. We ask that you contact us at [insert contact information] as soon as possible to confirm your ability to return to work on or before that date.

[Optional – fitness-for-duty certification]

Because you took FMLA leave for your own serious health condition, you must provide a certification from your health care provider that addresses your ability to perform the essential functions of your position (with or without a reasonable accommodation). Enclosed is a copy of your job description to provide to your health care provider.

If you are unable to return to work on [insert date], you must contact us prior to that date to discuss your situation. Depending on the circumstances, you may be eligible for additional, non-FMLA leave, such as leave as a reasonable accommodation under the federal Americans with Disabilities Act (ADA) due to your health condition. However, in order for a leave extension to be considered, you must contact us to request additional time off from work. You may be asked to provide medical information to support your need for additional leave.

If you do not return to work (and you have not been approved for additional leave), your employment with this Company will terminate as of [insert date], in accordance with the FMLA and Company policy.

If you are receiving health plan coverage through the Company, your (and, if applicable, your enrolled dependents') eligibility for this coverage will also terminate in accordance with the plan's rules. However, you may be eligible to continue health plan coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

Sincerely,

[Insert name]

[Insert title]