USPS VERIFICATION OF VETERAN'S TREATMENT

Dear___________:

I ______________________, SS#____________________________ am a disabled veteran under treatment by the_________________VA facility. As required by my medical condition, it will be necessary that I be absent from work on occasion to receive medical treatment. My absence(s) to attend to the required treatment are covered by the Family and Medical Leave Act which permits the employer to demand medical certification of my treatment and condition.

The Veterans' Hospitals' have a policy of not completing FMLA forms. Due to this policy it will not be possible for me to provide documentation at your request; however, consistent with the provisions of the Family and Medical Leave Act, the employer's physician may contact the employee's physician with the consent of the employee. This letter is intended as my consent to have your designated physician contact my physician to verify:

- ✓ Whether my condition meets the definition of a Serious Health Condition
- ✓ The date of treatment
- ✓ Duration of condition
- ✓ Will I be off work intermittently or work a reduced schedule, if continuing treatments are required
- ✓ The nature and regimen of treatments, if continuing treatments are required, length of absence required and estimated dates of treatments, if known and any physical restrictions, including duration.
- ✓ Nature of my illness.

This is not to be interpreted that I am authorizing the employer or the employer's physician to inquire of the diagnosis or prognosis of my condition.

____________________________________ ____

Employee's Signature Dated