[Date]

[Medical Provider Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

RE: Medical Certification for [Patient/Employee Name]

Dear [Medical Provider Name],

I am writing to request a formal medical certification regarding my current health status and my ability to perform my job duties. My employer requires this documentation to process my request for medical leave of absence.

Please provide a statement or complete the attached form confirming the following information:

- The date the medical condition commenced.
- The probable duration of the condition.
- Whether I am unable to perform one or more of the essential functions of my job.
- The expected duration of the leave (start date and anticipated return-to-work date).

Please do not include specific genetic information or a detailed diagnosis if it is not required by law, as this information is for the purpose of verifying the need for leave only.

You may provide the completed documentation directly to me or fax it to my employer's Human Resources department at [Fax Number] by [Deadline Date].

Thank you for your assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Employee ID, if applicable]
[Your Phone Number]