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

[Date]

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

RE: Medical Certification Request for [Patient Name]
Date of Birth: [Patient Date of Birth]

Dear [Provider Name],

We are writing to request a formal medical certification regarding the above-named patient. This documentation is required for the purpose of [State Purpose, e.g., Family Medical Leave (FMLA), Reasonable Accommodation, Disability Benefits, or Return to Work].

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

- Confirmation of a serious health condition or qualifying medical diagnosis.
- The date the condition commenced and the expected duration.
- Specific medical restrictions or limitations affecting [Patient Name]'s ability to perform essential job functions.
- Frequency and duration of any required intermittent leave or follow-up treatments.

Attached is a signed medical release authorization from the patient allowing you to share this information with [Organization Name].

Please submit the completed certification via fax to [Fax Number] or via secure email to [Email Address] by [Deadline Date].

Thank you for your time and assistance in this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title]

Enclosure: [Signed Release of Information / Specific Certification Form]