[Date]

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

RE: Certification of Health Care Provider for Employee's Serious Health Condition

Dear [Employee Name],

Enclosed please find the completed "Certification of Health Care Provider for Employee's Serious Health Condition" form as requested for your medical leave application.

Our clinical staff has reviewed your medical records and completed the relevant sections regarding your diagnosis, the commencement of the condition, and the probable duration of the required treatment or recovery period. We have also addressed the essential job functions you are unable to perform at this time.

Please review the document to ensure all personal information is correct before submitting it to your employer's Human Resources department. Please note that it is your responsibility to meet any deadlines set by your employer regarding the submission of this documentation.

If your employer requires further clarification or if your medical status changes significantly, please contact our office to schedule a follow-up appointment.

Sincerely,

[Provider Name or Medical Records Department]
[Clinic/Hospital Name]
[Phone Number]