DATE: [Date]

TO: [Employee Name]

FROM: [Employer/HR Representative Name]

SUBJECT: Request for Second Medical Opinion regarding FMLA Certification

Dear [Employee Name],

We have received the "Certification of Health Care Provider for Employee's Serious Health Condition" submitted on [Date] in support of your request for family and medical leave.

After reviewing the documentation provided, the company has reason to doubt the validity of the certification for the following reason(s):

[Insert brief, objective reason for doubt, e.g., conflicting information or need for further clarification].

In accordance with the Family and Medical Leave Act (FMLA) regulations, [Company Name] is exercising its right to require you to obtain a second medical opinion. This opinion will be at the company's expense.

We have scheduled an appointment for you with the following health care provider, who is not regularly employed by this company:

Provider Name: [Doctor Name]
Specialty: [Medical Specialty]
Address: [Facility Address]
Date/Time: [Appointment Date and Time]

Please note the following:

- The company will pay for the cost of this examination and any reasonable travel expenses incurred.
- You are required to authorize the release of the relevant medical information from your initial certification to this second-opinion provider.
- Failure to cooperate with this request may result in the delay or denial of your FMLA leave request.

If the second opinion differs from your initial certification, the company may require a third and binding opinion from a health care provider mutually agreed upon by both you and the company.

Please contact [HR Contact Name] at [Phone Number/Email] to confirm your attendance or if you have any questions regarding this process.

Sincerely,

[Signature]
[Typed Name]
[Title]