Date: [Date]

To: [Employee Name]

Employee ID: [ID Number]

Subject: Requirement for Medical Recertification of Serious Health Condition

Dear [Employee Name],

Our records indicate that you are currently approved for leave under the Family and Medical Leave Act (FMLA) for your own serious health condition. This letter is to inform you that we require updated medical documentation to support your ongoing need for leave or workplace accommodations.

Under company policy and FMLA guidelines, we are requesting a medical recertification from your health care provider at this time because:

- The minimum duration of your previous certification has expired.
- The circumstances described by your previous certification have changed significantly.
- We have received information that casts doubt upon your stated reason for the absence or the continuing validity of the certification.

Please find the enclosed "Certification of Health Care Provider for Employee's Serious Health Condition" form. You are required to have your health care provider complete this form and return it to the Human Resources Department no later than **[Insert Date - at least 15 calendar days from now]**.

Failure to provide a complete and sufficient medical recertification within the specified timeframe may result in the delay or denial of your leave protection and could impact your employment status.

If you have any questions regarding this request or if there are circumstances preventing you from returning this form by the deadline, please contact me immediately at [Phone Number] or [Email Address].

Sincerely,

[Your Name]
[Your Title]
[Company Name]

Enclosure: Medical Certification Form