[Date]

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

RE: Authentication of Medical Certification for [Employee Name]

Dear [Health Care Provider Name],

We have received the medical certification form submitted by [Employee Name] in connection with a request for leave under the Family and Medical Leave Act (FMLA).

In accordance with 29 C.F.R. $ 825.307, we are seeking authentication of this document. We are providing you with a copy of the certification as it was submitted to us. Please review the attached document and confirm the following:

- That the information contained in the certification was completed and/or authorized by you.
- That the signature on the document is your own or that of an authorized representative of your office.

Please note that we are not requesting additional medical information or a clarification of the diagnosis. We are only seeking to verify that the information on the form was actually provided by your office.

You may provide this verification by signing below or by contacting our office directly at [Phone Number] or [Email Address].

Thank you for your assistance in this matter.

Sincerely,

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

Provider Verification:

I hereby confirm that the attached Medical Certification was completed and signed by me or my authorized representative.

Signature: _____ Date: _____