Date: [Insert Date]

To: [Employer Name/HR Department]
Address: [Employer Address]

Subject: Medical Certification for Covered Servicemember (FMLA)

Patient Name: [Servicemember Name]
Relationship to Employee: [Relationship to Employee, e.g., Spouse/Child/Parent/Next of Kin]

To whom it may concern,

I am a health care provider authorized to certify medical conditions for the above-named patient. This letter serves as the initial medical certification regarding the patient's serious injury or illness incurred in the line of duty on active duty in the Armed Forces.

1. Medical Status:
The patient is a (check one):
[ ] Current member of the Regular Armed Forces, National Guard, or Reserves.
[ ] Veteran who was a member of the Armed Forces at any time during the five years preceding the date of this treatment.

2. Condition Details:
The patient is undergoing medical treatment, recuperation, or therapy for a serious injury or illness that may render the servicemember medically unfit to perform the duties of their office, grade, rank, or rating.

3. Estimated Leave Requirements:
The patient requires care from [Employee Name]. The estimated period of care is from [Start Date] to [End Date]. Treatment is expected to be (check one):
[ ] Continuous leave
[ ] Intermittent leave (Estimated frequency: [Frequency] per month)

4. Healthcare Provider Information:

Name: [Provider Name]
Type of Practice/Medical Specialty: [Specialty]
Clinic Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]

Sincerely,

(Signature)
_____
[Printed Name and Title]