[Date]

[Medical Provider Name]
[Clinic Name]
[Clinic Address]
[City, State, Zip Code]

RE: Medical Recertification for [Servicemember Name]
DOB: [Servicemember Date of Birth]
Last 4 of SSN: [Last 4 Digits]

Dear **[Doctor Name]**,

I am writing to request a medical recertification regarding the current health status and treatment plan for the above-named servicemember. This documentation is required for **[reason, e.g., extension of medical leave, continued disability benefits, or fitness for duty evaluation]**.

Please provide an updated assessment that includes the following information:

- Current diagnosis and clinical status of the injury/illness.
- Progress made since the last evaluation on **[Date of last evaluation]**.
- Expected duration of continued treatment or recovery.
- Any specific physical or cognitive limitations that impact duty performance.
- The date of the next scheduled follow-up appointment.

Please find the attached signed release of information form. You may return the completed documentation via fax to **[Fax Number]** or via secure email to **[Email Address]**.

Thank you for your continued care of this servicemember and your prompt attention to this request. Should you have any questions, please contact me at **[Your Phone Number]**.

Sincerely,

[Your Signature]

[Your Printed Name]
[Your Title/Unit, if applicable]