

**Date:** [Date]

**To:** [Healthcare Provider Name]  
[Clinic/Hospital Name]  
[Address]  
[City, State, Zip Code]

**Re: FMLA Certification for [Employee Name]**  
**Patient Date of Birth:** [DOB]

Dear [Healthcare Provider Name],

We received the Family and Medical Leave Act (FMLA) certification form submitted for the above-mentioned employee on [Date].

Upon review, we found that the document is incomplete. Specifically, the following information is missing:

- **Provider Signature:** The certification form was not signed by the attending healthcare provider.
- **Date of Signature:** Please ensure the document is dated at the time of signing.

Under the Department of Labor regulations, a signature is required to authenticate the medical facts provided. Please sign and date the attached form (see highlighted section) and return it to our office by [Deadline Date].

You may return the completed document via:

- **Fax:** [Fax Number]
- **Email:** [Email Address]
- **Mail:** [Mailing Address]

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]  
[Your Title]  
[Company Name]  
[Phone Number]