[Date]

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

RE: Clarification of FMLA Medical Certification for [Employee Name]

Dear **[Healthcare Provider Name]**,

We have received the Family and Medical Leave Act (FMLA) certification form you completed for **[Employee Name]** on **[Date of original form]**.

Upon review, we require additional clarification regarding the duration of the employee's incapacity to ensure we provide the appropriate leave benefits. Specifically, the following section(s) require further detail:

- **Section [Number/Name]:** The duration of the incapacity is listed as [Current Entry, e.g., "Unknown" or "Indefinite"]. Please provide a specific estimate of the beginning and ending dates for the period of incapacity.
- **Frequency/Duration:** For intermittent leave, please clarify the estimated frequency of flare-ups (e.g., number of episodes per month) and the duration of each episode (e.g., hours or days per episode).

Under FMLA regulations, an employer may request clarification to understand the handwriting or the meaning of a response on the certification. We are not seeking new information or a diagnosis, only a clear explanation of the timeframes already indicated.

A copy of the original certification is attached for your reference. Please provide the clarified information by **[Date - typically 7 days]** to ensure the employee's leave is processed without delay.

The employee has provided a signed release allowing us to seek this specific clarification. Thank you for your assistance.

Sincerely,

[Your Name/Signature]
[Your Title]
[Company Name]
[Phone Number]
[Email Address]