[Company Name]
[Human Resources Department]
[Address]
[City, State, Zip Code]

[Date]

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

RE: Request for Clarification of FMLA Medical Certification

Patient Name: [Employee Name]
Date of Birth: [DOB]

Dear [Health Care Provider Name],

We received the Family and Medical Leave Act (FMLA) certification for the above-named employee on [Date]. Upon review, we find that the certification is incomplete or insufficient regarding the serious health condition details required to determine FMLA eligibility.

Specifically, we require clarification on the following sections:

- [Specify missing detail, e.g., Section stating the date the condition commenced.]
- [Specify missing detail, e.g., Information regarding the probable duration of the condition.]
- [Specify missing detail, e.g., Description of the medical facts sufficient to support the need for leave.]

Pursuant to 29 C.F.R. $ 825.307, we are providing the employee with seven (7) calendar days to cure these deficiencies. We have attached a copy of the original certification and a signed medical release from the employee.

Please provide the clarified information by [Date] to ensure the employee's leave request is processed accurately. You may fax the updated form to [Fax Number] or mail it to the address listed above.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]
[Your Title]

[Phone Number]
[Email Address]