

Date: [Insert Date]

To: [Insert Name of Healthcare Provider]

Address: [Insert Provider Address]

Fax/Email: [Insert Provider Fax or Email]

RE: Clarification of FMLA Certification for [Employee Name]

Dear [Name of Healthcare Provider],

We have received the Family and Medical Leave Act (FMLA) certification for our employee, [Employee Name], dated [Date on Certification Form].

Upon review, we require further clarification regarding the anticipated duration of the leave. The current certification provides an ambiguous return-to-work date or duration (e.g., "unknown," "indefinite," or "TBD"). To properly administer FMLA benefits and manage workplace coverage, we require a more specific estimate of when the employee is expected to be able to return to work, even if that date is subject to future re-evaluation.

Information Requested:

- A specific estimated date for the employee's return to work; or
- A specific timeframe (e.g., number of weeks or months) for the duration of the incapacity.

Please provide this clarification by [Insert Date - typically 7 days from receipt]. You may provide this information by updating the original certification form or by sending a supplemental letter to our Human Resources department at [Insert Fax Number or Email Address].

A copy of the employee's signed authorization for the release of health information is attached to this request.

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Name]

[Your Title]

[Company Name]

[Phone Number]