Date: [Insert Date]

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

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

Dear [Health Care Provider Name],

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

Upon review, we found that the information provided regarding the treatment schedule is incomplete or unclear. Specifically, the certification states that the employee requires "unspecified" or "to be determined" treatment intervals. To determine the employee's eligibility and to manage workplace scheduling, we require further clarification under the Department of Labor regulations (29 C.F.R. $ 825.307).

Please provide additional information regarding the following:

- The estimated frequency of the treatment (e.g., number of times per week or month).
- The estimated duration of each treatment episode (e.g., hours or days per visit).
- The anticipated period of recovery required after each treatment session, if applicable.

Please provide this clarification by [Insert Date - typically 7 days]. You may return the updated information via fax to [Insert Fax Number] or by mail to the address listed below.

A signed authorization from the employee allowing you to clarify this information with us is attached.

Sincerely,

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

Enclosure: Signed Employee Authorization for Release of Information