DATE: [Date]

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

RE: Clarification of FMLA Certification for [Employee Name]

Patient Name: [Patient Name]

Dear [Health Care Provider Name],

We have received the Family and Medical Leave Act (FMLA) certification for our employee, [Employee Name], to provide care for [Patient Name].

Upon review, the documentation is incomplete regarding the specific care requirements. To determine FMLA eligibility, please provide clarification on the following missing information:

- Verification that the patient requires assistance for basic medical, hygienic, nutritional, safety, or transportation needs.
- Confirmation that the employee's presence is necessary to provide psychological comfort or physical care.
- The estimated frequency and duration of the care needed (e.g., number of hours per day or days per week).

Under FMLA regulations, the employee has seven calendar days to provide this clarification. Please return the updated information or a letter of clarification by [Due Date] via fax to [Fax Number] or email to [Email Address].

Thank you for your assistance in this matter.

Sincerely,

[Your Name]
[Your Title]
[Company Name]