

[Date]

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

**RE: Medical Certification for Intermittent Leave**

To Whom It May Concern,

I am the treating physician for [Patient Name], who is under my care for a chronic medical condition. This condition is permanent and requires ongoing medical management.

Due to the nature of this condition, [Patient Name] will require intermittent leave from work. This leave is necessary for periodic flare-ups that prevent the patient from performing their essential job functions and for attending scheduled medical treatments or follow-up appointments.

**Frequency and Duration:**

- **Flare-ups:** It is estimated that the patient may experience episodes [Number] times per [Week/Month], lasting approximately [Number] days per episode.
- **Medical Appointments:** The patient will require leave for appointments approximately [Number] times per [Month].

This certification is effective from [Start Date] through [End Date/Expected Duration]. We will re-evaluate the patient's status at the end of this period if necessary.

If you require further clarification regarding this medical necessity, please contact my office directly at [Phone Number].

Sincerely,

[Physician Signature]  
[Physician Printed Name]  
[Medical License Number]  
[Clinic/Hospital Name]