Date: [Insert Date]

To: [Employee Name]
Employee ID: [Insert ID]
Address: [Insert Address]

Subject: Certification for Extension of Family and Medical Leave (FMLA)

Dear [Employee Name],

Our records indicate that your current approved FMLA leave for a chronic health condition is scheduled to expire or has reached the end of the previous certification period on [Current Expiration Date].

To continue your FMLA protection and extend your leave, we require updated medical certification from your healthcare provider. This documentation must confirm that the chronic health condition still requires intermittent or continuous leave and provide an estimated frequency and duration for future absences.

Please find the attached **"Certification of Health Care Provider"** form. You must return the completed form to the Human Resources Department no later than **[Insert Deadline Date, usually 15 days]**.

Failure to provide the requested medical certification within the specified timeframe may result in the delay or denial of your leave extension, and subsequent absences may be treated as unexcused under the company's attendance policy.

If you have any questions regarding this extension process or your FMLA entitlements, please contact [Contact Person/Department Name] at [Phone Number/Email].

Sincerely,

[Your Name/Signature]
[Your Title]
[Company Name]

Enclosure: Certification of Health Care Provider Form