

[Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Subject: Notification of Second Medical Opinion Requirement for FMLA Request

Dear [Employee Name],

We have received the medical certification submitted on [Date] in support of your request for leave under the Family and Medical Leave Act (FMLA). After reviewing the documentation, [Company Name] has reason to doubt the validity of the certification provided.

In accordance with FMLA regulations (29 CFR § 825.307), the company is exercising its right to require a second medical opinion at the company's expense. This second opinion will determine your eligibility for FMLA leave.

Appointment Details:

- **Provider Name:** [Doctor/Clinic Name]
- **Specialty:** [Type of Practice]
- **Address:** [Address of Clinic]
- **Date and Time:** [Date] at [Time]

Please note that the healthcare provider selected for this second opinion is not regularly employed by [Company Name].

Employee Obligations:

- You are required to attend this appointment. Failure to cooperate may result in the denial of your FMLA leave request.
- You are authorized to release relevant medical records pertaining to the condition in question to the provider listed above.
- The company will reimburse you for reasonable travel expenses incurred to attend this appointment. Please keep all receipts.

While the second opinion is pending, you are provisionally entitled to FMLA leave. Once we receive the results from the healthcare provider, we will notify you of the status of your leave request. In the event of a conflict between the first and second opinions, a third and binding opinion may be required.

If you have any questions regarding this process, please contact [HR Contact Name] at [Phone Number/Email].

Sincerely,

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