

[Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Re: Denial of Family and Medical Leave Act (FMLA) Request

Dear [Employee Name],

We are writing to inform you that your request for leave under the Family and Medical Leave Act (FMLA) has been denied. This decision is based on the following reason(s):

- Failure to provide a completed Medical Certification form.
- The medical certification provided was incomplete or insufficient, and the deficiencies were not corrected within the 7-day cure period.
- The medical documentation provided does not support a "serious health condition" as defined by FMLA regulations.
- You have exhausted your 12-week FMLA leave entitlement for the current 12-month period.
- You do not meet the eligibility requirements (e.g., length of service or hours worked).
- Other: [Specify Reason]

As a result of this denial, your absences starting on [Date] will not be designated as FMLA-protected leave. These absences will be handled according to the clinic's standard attendance and paid time off policies.

If you believe there has been an error or if you have additional information you would like us to consider, please contact the Human Resources Department immediately.

Sincerely,

[Name]

[Title]

[Clinic Name]