

[Date]

[Employee Name]
[Employee ID]
[Clinic Department]

Subject: Notice of Denial of Family and Medical Leave (FMLA)

Dear [Employee Name],

On [Date], we received your request for Family and Medical Leave (FMLA) for [Reason for Leave]. Along with your request, we received medical certification documentation from your healthcare provider.

We are writing to inform you that your request for FMLA leave has been **denied** at this time due to **insufficient evidence**.

The documentation provided did not meet the requirements for the following reason(s):

- The medical certification was incomplete (missing required signatures or dates).
- The certification does not provide enough medical facts to support a serious health condition.
- The duration or frequency of the leave was not specified.
- The documentation does not establish a connection between the medical condition and the need for leave.

As per our previous communication dated [Date of Incomplete Notice], you were given seven (7) calendar days to cure these deficiencies. As of today, we have not received the necessary supplemental information required to approve your leave.

Because your leave is not FMLA-protected, any absences related to this request will be subject to the clinic's standard attendance and call-in policies. This may result in the use of your paid time off (PTO) or unpaid leave, and could impact your attendance record.

If you obtain the required medical information in the future, you may submit a new certification for reconsideration. Please contact the Human Resources Department at [Phone Number] or [Email Address] if you have questions regarding this decision.

Sincerely,

[Name]
[Title]
[Clinic Name]