[Date]

[Employee Name]
[Employee ID]
[Department]

**Subject: Denial of FMLA Leave Request**

Dear [Employee Name],

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA), which was received on [Date]. After careful consideration of your application and supporting documentation, we regret to inform you that your request has been denied for the following reason(s):

- [ ] You have not been employed by the facility for at least 12 months.
- [ ] You have not worked at least 1,250 hours during the 12-month period immediately preceding the leave.
- [ ] You work at a location where the facility employs fewer than 50 employees within a 75-mile radius.
- [ ] The medical certification provided was incomplete or insufficient and was not corrected within the requested timeframe.
- [ ] Your medical condition does not meet the definition of a "serious health condition" under FMLA guidelines.
- [ ] You have already exhausted your 12-week FMLA entitlement for the current 12-month period.
- [ ] Other: [Specify reason]

While your leave is not protected under FMLA, you may be eligible for other types of leave or accommodations under our facility's internal policies or the Americans with Disabilities Act (ADA). We encourage you to contact the Human Resources Department to discuss alternative options.

If you believe this decision has been made in error or if you have additional documentation to provide, please contact HR at [Phone Number/Email] by [Deadline Date].

Sincerely,

[Name]
[Title]
[Healthcare Facility Name]