

Date: [Date]

To: [Employee Name]

Employee ID: [Employee ID Number]

Subject: Notice Regarding Periodic FMLA Certification Update

Dear [Employee Name],

Our records indicate that you are currently using leave under the Family and Medical Leave Act (FMLA) for [Reason: your own serious health condition / the serious health condition of a family member].

To ensure our records remain accurate and to confirm your continued eligibility for this leave, we require a periodic update regarding your medical certification. Under FMLA regulations, an employer may request recertification for ongoing leave conditions.

Please find the attached "Certification of Health Care Provider" form. You must have your healthcare provider complete this form and return it to the Human Resources Department by [Date: 15 days from now].

Failure to provide the requested recertification within the specified timeframe may result in the delay or denial of continued FMLA protection for your absences.

If your medical circumstances or your need for leave have changed, or if you have already returned to full duty, please notify us immediately.

If you have any questions regarding this request, please contact [Contact Name/Department] at [Phone Number] or [Email Address].

Sincerely,

[Your Name/Signature]

[Title]

[Company Name]