Date: [Insert Date]

To: [Employer Name/Human Resources Department]
Company: [Company Name]
Address: [Company Address]

RE: Medical Certification for FMLA Leave
Employee Name: [Employee Full Name]
Date of Birth: [Employee DOB]

To Whom It May Concern,

I am the treating physician for [Employee Name]. This letter serves as formal medical certification to support the employee's request for leave under the Family and Medical Leave Act (FMLA).

Medical Condition and Necessity:
The patient has a serious health condition as defined by FMLA guidelines. Due to this condition, it is medically necessary for the patient to be absent from work to receive treatment and/or for recovery.

Duration of Leave:
The patient will require a period of leave beginning on [Start Date]. It is estimated that the patient will be able to return to work on or about [End Date/Return Date].

Schedule (Check one):
[ ] **Continuous Leave:** The patient is unable to work for a continuous block of time.
[ ] **Intermittent Leave:** The patient's condition may result in episodic flare-ups or the need for periodic medical appointments, requiring intermittent leave of approximately [Number] hours/days per [Week/Month].

Capacity to Work:
During the leave period, the patient is: (Select one)
[ ] Entirely unable to perform any work functions.
[ ] Able to perform work functions with the following restrictions: [List restrictions if applicable].

I certify that the information provided is based on my clinical evaluation and the patient's current medical records. If you require further clarification regarding the medical necessity of this leave, please contact my office directly.

Sincerely,

[Physician Signature]

Physician Name: [Print Name]
Medical Specialty: [Specialty]
License Number: [License #]
Phone Number: [Phone Number]
Clinic/Hospital: [Facility Name]