

## MANAGEMENT REQUEST FOR CLARIFICATION OF MEDICAL CERTIFICATION

Employee's name \_\_\_\_\_

Date of Original Medical Certification \_\_\_\_\_

Supervisor \_\_\_\_\_

You verbally requested on \_\_\_\_\_ that I obtain clarification of my medical certification. I shall need more specific information regarding your request. The Family and Medical Leave Act provides that you are entitled to:

- \*The name of my health care provider and the type of medical practice
- \* A certification of which part of the definition applies to my condition
- \*A brief statement as to how the medical facts meet the criteria of the definition
- \*The date the serious health condition commenced and its probable duration,
- \*Whether my absence will be intermittent or require a reduced work schedule
- \*Additional treatments, if necessary
- \*If pregnancy or chronic condition, will I require a reduced leave schedule or intermittent leave
- \*The nature of treatments provided by a different provider
- \*The regimen of continuing treatment if required
- \*Whether or not I can perform work of any kind or the essential functions of my position

The Family and Medical Leave Act requires that ***you provide me with advance written notice detailing the specific expectations and obligations.*** This is to request that you provide me in writing whether you request the opportunity to contact my physician and the specific clarification of my certification that you seek.

\_\_\_\_\_  
Employee's Signature