

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