FMLA PHYSICIAN CERTIFICATION REQUEST LETTER

DATE:

Attending Physician of ____________________________________
Address
Anywhere, TX 00000

Dear Attending Physician,

_________________________________, an employee of the Dallas County Community College District has been granted leave under the Family Medical Leave Act of 1993, for an illness diagnosed under your care.

In accordance with FMLA guidelines, we are required to have you complete and return the enclosed form "Certification of Health Care Provider." The job description currently for the position currently held by this employee is enclosed to assist you in completing the form.

Please return the completed form in the envelope provided. Your promptness in this matter will be greatly appreciated.

Sincerely,

Your Name Here
Your Title Here

c: FMLA File