Dear ________,

It appears that you may have a health related condition that may constitute a serious health condition under the Family Medical Leave Act (FMLA). Enclosed is a health care certification provider form that is from the U.S. Department of Labor. You must have your health care provider complete this form. It is your responsibility to return the form to me within fifteen days. Failure to return the form in this time frame could result in denial of FMLA leave and discipline for insubordination.

Note- Some changes will be needed if the leave is due to a serious health condition of a family member.