Date: [Insert Date]

To: [Employee Name]
Employee ID: [Insert ID]

From: [Clinic Name/HR Department]
Subject: Designation Notice - Family and Medical Leave (FMLA)

Dear [Employee Name],

We have reviewed your request for leave to care for your family member, [Family Member Name], and the medical certification provided by the treating physician.

Leave Approval:
Your request for leave under the Family and Medical Leave Act (FMLA) is **APPROVED**. Your leave is designated as FMLA-protected leave for the following period:

Start Date: [Insert Date]
End Date: [Insert Date or "Ongoing"]

Leave Schedule:
[ ] Continuous Leave
[ ] Intermittent Leave (As needed based on medical necessity)

Your Responsibilities:
1. You must comply with our clinic's standard call-in procedures for each absence.
2. When requesting time off, you must specifically mention your "FMLA" or "Approved Caregiver Leave."
3. You are required to use your accrued [Sick/Vacation/PTO] hours concurrently with this leave until exhausted.

Benefit Maintenance:
During your leave, the clinic will maintain your health insurance coverage under the same conditions as if you had continued to work. You remain responsible for your portion of the premium payments.

Return to Work:
Upon your return from FMLA leave, you will be reinstated to your same position as a Clinic Pharmacist or to an equivalent position with equivalent pay, benefits, and other terms of employment.

If you have any questions regarding your leave entitlement or responsibilities, please contact [HR Name/Department] at [Phone Number/Email].

Sincerely,

[Your Name]
[Your Title]
[Clinic Name]