Date: [Date]

To: [Employee Name]
Position: [Job Title]
Department: [Clinic Name/Department]

Subject: Authorization for Intermittent FMLA Leave

Dear [Employee Name],

This letter is to formally notify you that your request for Family and Medical Leave Act (FMLA) leave has been approved on an **intermittent basis**. This approval is based on the medical certification provided by your healthcare provider.

1. Period of Approval:
Your intermittent leave is authorized beginning [Start Date] and is expected to continue through [End Date or Re-evaluation Date].

2. Authorized Frequency and Duration:
Based on your medical certification, your leave is approved for:
- Frequency: [e.g., 1-2 episodes per month]
- Duration: [e.g., 1-3 days per episode or hours per day]

3. Reporting Procedures:
As clinic staff, maintaining patient care standards is a priority. You are required to follow standard department call-in procedures for every absence. When reporting your absence, you must specifically state that the leave is for "FMLA" to ensure hours are tracked correctly.

4. Scheduling Medical Appointments:
For planned medical treatments or appointments, you must make a reasonable effort to schedule them so as not to unduly disrupt clinic operations. Please provide your supervisor with as much advance notice as possible.

5. Tracking Leave:
All hours taken under this authorization will be deducted from your total 12-week FMLA entitlement. You are responsible for recording your FMLA hours on your timesheet as [Insert Specific Pay Code, e.g., FMLA-Unpaid or FMLA-Sick].

Please contact the Human Resources Department at [Phone Number] if you have questions regarding your FMLA benefits or if your medical needs change significantly.

Sincerely,

[Signature]
[Name of HR Representative/Manager]
[Title]

Employee Acknowledgment:

I acknowledge that I have received this authorization and understand the requirements for reporting and using my intermittent FMLA leave.

Signature: ___________________________ Date: __________