Date: [Date]

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

Subject: Approval of Intermittent FMLA Leave for Chronic Health Condition

Dear [Employee Name],

This letter is to formally notify you that your request for Family and Medical Leave Act (FMLA) leave has been approved. Based on the medical certification provided by your healthcare provider, your leave is authorized on an intermittent basis to manage your chronic health condition.

Authorization Details:

- **Effective Date:** [Start Date]
- **Expiration Date:** [End Date/Recertification Date]
- **Frequency:** Up to [Number] episodes per [Week/Month]
- **Duration:** Approximately [Number of Hours/Days] per episode

Employee Responsibilities:

1. **Reporting Absences:** You must follow the clinic's standard call-in procedures for every absence. When calling in, you must specifically state that the absence is for "FMLA" to ensure proper tracking.

2. **Scheduling:** For planned medical appointments or treatments, 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.

3. **Time Tracking:** You are required to accurately record all FMLA-related hours on your timecard or via the clinic's designated leave tracking system.

Benefit Protections:

During your FMLA leave, your health insurance benefits will be maintained under the same conditions as if you had continued to work. You remain responsible for your portion of the insurance premiums. Upon your return from FMLA leave, you will be reinstated to your original position or an equivalent position with equivalent pay and benefits.

Please contact the Human Resources Department if you have any questions regarding your leave entitlement or responsibilities.

Sincerely,

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

cc: Personnel File