

**Date:** [Date]

**To:** [Employer Name/HR Department]

**From:** [Physician Name, MD/DO]

**Subject:** Intermittent FMLA Leave Schedule Authorization

**Patient Name:** [Patient Full Name]

**Patient Date of Birth:** [DOB]

To Whom It May Concern,

I am the attending physician for the above-named patient. This letter serves to certify the medical necessity for the patient to take intermittent leave under the Family and Medical Leave Act (FMLA) due to a serious health condition.

Based on my medical evaluation, the patient requires a modified work schedule or periodic absences for treatment and/or recovery. The anticipated frequency and duration of the intermittent leave are as follows:

- **Estimated Frequency:** [e.g., 1-2 times per week / 1-2 times per month]
- **Estimated Duration:** [e.g., 4-8 hours per episode / 1-2 days per episode]
- **Effective Dates:** From [Start Date] to [End Date/Re-evaluation Date]

The patient may experience flare-ups that are unpredictable in nature, necessitating immediate leave. Additionally, leave is required for scheduled medical appointments and follow-up care related to their condition.

If you require further clarification regarding the medical necessity of this schedule, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Specialty]

[Clinic/Facility Name]