

[Date]

[Employee Name]

[Employee ID]

[Department]

Subject: Approval of Intermittent FMLA Leave

Dear [Employee Name],

We have reviewed your request for Family and Medical Leave Act (FMLA) leave and the supporting medical certification provided by your healthcare provider. This letter serves as official notification that your request for **intermittent leave** has been approved.

Leave Details:

- **Reason for Leave:** [Self / Family Member] Medical Condition
- **Effective Date:** [Start Date]
- **Expiration Date:** [End Date / Recertification Date]
- **Approved Frequency:** [e.g., Up to 2 episodes per month]
- **Approved Duration:** [e.g., 1-2 days per episode]

Employee Responsibilities:

- **Call-In Procedures:** You must follow the clinic's standard call-in procedures for every absence. When reporting your absence, you must specifically state that the leave is for "FMLA" to ensure proper tracking.
- **Scheduling:** To the extent possible, you are required to make a reasonable effort to schedule planned medical treatments so as not to unduly disrupt clinic operations.
- **Time Tracking:** You must accurately record all FMLA hours used on your timesheet or via [Specific Tracking System].

Please note that FMLA leave is unpaid; however, you may be required to use your accrued paid time off (PTO/Sick Leave) concurrently with your FMLA leave as per clinic policy.

If you have any questions regarding your leave entitlement or these requirements, please contact the Administration Office.

Sincerely,

[Signature]

[Name of Clinic Administrator]

[Title]

[Clinic Name]