Date: [Date]

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

Subject: Authorization for Reduced FMLA Work Schedule

Dear [Employee Name],

This letter is to formally notify you that your request for a reduced work schedule under the Family and Medical Leave Act (FMLA) has been approved. This authorization is based on the medical certification provided by your healthcare provider.

Approved Schedule Details:

- **Effective Start Date:** [Start Date]
- **Anticipated End Date:** [End Date/Review Date]
- **Authorized Hours:** You are authorized to work [Number] hours per week.
- **Specific Shift/Days:** [Insert specific days or hours, e.g., Monday-Wednesday, 8:00 AM to 1:00 PM]

Terms of Leave:

The hours you do not work will be deducted from your total FMLA entitlement of 12 weeks (calculated on an hourly basis). You are required to follow standard clinic call-in procedures for any additional absences beyond this agreed-upon schedule.

Please ensure that your clinical tasks and patient handovers are completed or assigned to the appropriate staff members before the end of your scheduled shift to maintain continuity of care.

If you have any questions regarding your benefits, pay, or the duration of this leave, please contact the Human Resources Department.

Sincerely,

[Signature]
[Name of Manager or HR Representative]
[Title]
[Clinic Name]