[Medical Practice Name]
[Doctor Name/Provider Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

To: [Employer Name/Human Resources Department]
[Company Name]
[Address]

RE: Authorization for Modified FMLA Working Hours

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

To Whom It May Concern,

This letter serves as official medical authorization for [Patient Name] to participate in a modified work schedule under the Family and Medical Leave Act (FMLA) due to a serious health condition.

Based on my clinical evaluation, I recommend that the patient's working hours be modified as follows:

Effective Dates: [Start Date] to [End Date/Re-evaluation Date]
Maximum Hours Per Day: [Number of Hours]
Maximum Hours Per Week: [Number of Hours]
Frequency of Schedule: [e.g., 3 days per week / shortened daily shifts]

These restrictions are medically necessary to accommodate the patient's treatment plan and recovery process. We will re-evaluate the patient's status on [Date] to determine if further modifications or a return to full duty is appropriate.

If you require additional information or clarification regarding these medical limitations, please contact our office directly.

Sincerely,

[Doctor Signature]

[Doctor Name, Credentials]
[Medical License Number]