Date: [Date]

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

RE: FMLA Reduced Work Schedule Authorization
Employee Name: [Employee Full Name]
Date of Birth: [Employee DOB]

To Whom It May Concern,

I am the treating healthcare provider for [Employee Name]. This letter serves as medical certification for a reduced work schedule under the Family and Medical Leave Act (FMLA) due to a serious health condition.

Medical Necessity:
The patient has a medical condition that requires a temporary reduction in their standard working hours to accommodate treatment, recovery, or symptom management.

Authorized Schedule:
Effective [Start Date], I recommend the employee work a reduced schedule as follows:

- **Maximum Hours Per Day:** [Number] hours
- **Maximum Days Per Week:** [Number] days
- **Total Hours Per Week:** [Number] hours

Duration:
This reduced schedule is medically necessary from [Start Date] through [Expected End Date]. I will re-evaluate the patient's condition on [Follow-up Date] to determine if they can return to a full-time schedule or if an extension is required.

Functional Limitations:
During this period, the employee is able to perform their essential job functions but must adhere to the hour restrictions listed above to prevent aggravation of their medical condition.

If you require further clarification regarding this medical certification, please contact my office at [Phone Number].

Sincerely,

[Signature of Healthcare Provider]

[Printed Name of Healthcare Provider]
[Medical Credentials/Title]

[Practice/Facility Name]
[Phone Number]