Date: [Insert Date]

To: [Employee Name]
Position: [Nursing Job Title]
Department: [Unit/Department Name]

Subject: Authorization for FMLA Reduced 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.

Effective Dates:
The reduced schedule will begin on [Start Date] and is expected to continue until [End Date/Re-evaluation Date].

Approved Schedule:
Your modified hours will be as follows:
[List specific days and shift times, e.g., Monday-Wednesday, 0700 to 1500]

Tracking and Documentation:
As a member of the nursing staff, you are required to accurately document all hours worked. Any hours missed due to your FMLA-protected schedule reduction will be deducted from your total FMLA entitlement of 12 weeks. Please ensure you continue to follow standard department call-in procedures for any absences that fall outside of this pre-approved reduced schedule.

Benefits and Accruals:
Your health benefits will be maintained during this period. Please be advised that accruals for Paid Time Off (PTO) or sick leave may be adjusted proportionally based on your actual hours worked, in accordance with hospital policy.

If you have any questions regarding your leave entitlement or the impact on your benefits, please contact the Human Resources Department at [Phone Number/Email].

Sincerely,

[Signature]
[Name of HR Representative or Nurse Manager]
[Title]
[Facility Name]