[Medical Facility Name]
[Department Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Employer Name]
[Company Name]
[Human Resources Department]
[Street Address]
[City, State, Zip Code]

RE: Medical Certification for FMLA Reduced Work Schedule

To Whom It May Concern,

This letter serves as official medical notification that [Patient Full Name] is under my professional care for a serious health condition as defined by the Family and Medical Leave Act (FMLA).

Based on my clinical assessment, it is medically necessary for the patient to work a reduced hour schedule to manage their condition and/or undergo necessary treatments. This accommodation is required to ensure the patient's health and safety while maintaining employment capabilities.

Approved Reduced Schedule Details:

- **Effective Date:** [Start Date]
- **Estimated Duration:** [End Date or Number of Months]
- **Maximum Hours Per Day:** [Number] hours
- **Maximum Hours Per Week:** [Number] hours
- **Frequency of Treatment/Episodes:** [e.g., 2 times per week]

We will re-evaluate the patient's medical status on [Follow-up Date] to determine if the reduced schedule needs to be extended, modified, or if the patient can return to full-time duty.

If you require further clarification regarding the medical necessity of this schedule, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name, Degree]
[Medical License Number]
[Facility Stamp/Seal]