[Current Date]

[Employee Name]
[Employee ID]
[Department]

Subject: Authorization of Adjusted FMLA Work Schedule

Dear [Employee Name],

This letter is to formally notify you that [Clinic Name] has approved your request for an adjusted work schedule under the Family and Medical Leave Act (FMLA), based on the medical certification provided.

Your adjusted schedule is approved effective [Start Date] through [End Date, or "until further notice"]. Your specific working hours will be as follows:

- **Monday:** [Start Time] to [End Time]
- **Tuesday:** [Start Time] to [End Time]
- **Wednesday:** [Start Time] to [End Time]
- **Thursday:** [Start Time] to [End Time]
- **Friday:** [Start Time] to [End Time]

Please note the following conditions regarding your leave:

- **Leave Tracking:** The hours you do not work will be deducted from your total FMLA entitlement of 12 weeks per year.
- **Reporting:** You must continue to follow standard clinic call-in procedures for any additional absences beyond this approved schedule.
- **Recertification:** Should your medical needs change, or should the current certification expire, updated documentation from your healthcare provider will be required.
- **Communication:** Please keep your direct supervisor informed of any changes to your treatment schedule that may impact these hours.

If you have any questions regarding your benefits or your FMLA balance, please contact the Human Resources department.

Sincerely,

[Signature]
[Name of Clinic Administrator]
[Title]
[Clinic Name]