[Date]

[Employee Name]
[Employee ID]
[Department Name]

Subject: Approval of FMLA Reduced Work Schedule

Dear [Employee Name],

We have received your request for a reduced work schedule under the Family and Medical Leave Act (FMLA) beginning on [Start Date]. We have reviewed the medical certification provided and are pleased to inform you that your request has been approved.

Based on the medical necessity outlined by your healthcare provider, your approved work schedule will be as follows:

- **Effective Dates:** [Start Date] through [End Date/Review Date]
- **Approved Hours:** [Number of hours] per week / [Number of hours] per shift
- **Specific Schedule:** [Detail specific days and times, e.g., Monday-Wednesday, 8:00 AM to 12:00 PM]

Please note the following conditions regarding your leave:

- **FMLA Entitlement:** The hours you do not work will be deducted from your total 12-week FMLA entitlement.
- **Reporting Requirements:** You must continue to follow standard departmental call-in procedures for any additional absences not covered by this specific schedule.
- **Benefit Contributions:** If your reduced hours result in a change in pay, you remain responsible for your portion of health insurance premiums and other voluntary benefits.
- **Updates:** You must notify [Human Resources/Manager Name] immediately if there is any change to your medical condition or your ability to perform your duties.

In your role providing patient care, it is essential that we coordinate your schedule to ensure continuous coverage and patient safety. Please communicate closely with [Supervisor Name] regarding your shift hand-offs.

If you have any questions regarding your FMLA rights or this schedule, please contact the Human Resources Department at [Phone Number/Email].

Sincerely,

[Name]
[Title]
[Organization Name]