[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

RE: FMLA Certification - Reduced Work Schedule

Patient Name: [Patient Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter serves as formal medical certification regarding the above-named patient's request for Family and Medical Leave Act (FMLA) benefits. Due to a qualifying medical condition, it has been determined that the patient requires a temporary reduction in their work capacity.

Clinical Determination:
The patient is unable to perform their full-time duties at this time. I am recommending a reduced work schedule to accommodate their medical treatment and recovery process.

Approved Work Schedule:
Effective **[Start Date]** through **[Estimated End Date]**, the patient is restricted to the following schedule:

- Maximum hours per day: [Number]
- Maximum days per week: [Number]
- Specific restrictions: [e.g., No lifting over 10lbs, required 15-minute breaks every 2 hours]

The patient will be re-evaluated on **[Follow-up Appointment Date]** to determine if their work capacity can be increased or if the reduced schedule needs to be extended.

Please contact our office if you require any further clarification or formal FMLA forms to be completed.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical License Number]