Date: [Date]

To: [Employer Name / HR Department]
Company Name: [Company Name]
Address: [Company Address]

RE: Medical Certification for Reduced Work Schedule (FMLA)

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

Dear [Name of Contact Person or HR Manager],

I am the treating physician for [Patient Name]. This letter serves as formal medical authorization for a reduced work schedule under the Family and Medical Leave Act (FMLA) due to the patient's current medical condition.

To manage their health condition effectively, it is medically necessary for the patient to work a reduced schedule as follows:

- **Effective Dates:** From [Start Date] to [Estimated End Date].
- **Modified Hours:** The patient is limited to working [Number] hours per day and [Number] days per week.
- **Specific Schedule:** [Optional: Specify certain days or times, e.g., Monday-Wednesday only].

The patient will be re-evaluated on [Date] to determine if the reduced schedule needs to be extended or if they can return to full-time duties. Please let us know if additional FMLA certification forms are required.

Sincerely,

[Physician Signature]

Physician Name: [Typed Name]
Medical Specialty: [Specialty]
Clinic Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]