

[Date]

[Employee Name]

[Employee Address]

[City, State, Zip Code]

Subject: Approval of Family and Medical Leave (FMLA)

Dear [Employee Name],

We have reviewed your request for leave under the Family and Medical Leave Act (FMLA) which began/is scheduled to begin on [Start Date]. Based on the medical certification and documentation provided, your request for leave is officially approved.

Your leave is approved for the following reason:

Your own serious health condition.

The serious health condition of a family member.

The birth, adoption, or foster care placement of a child.

A qualifying exigency arising out of a family member's military service.

Your leave is approved as follows:

Leave Type: [Continuous / Intermittent / Reduced Schedule]

Expected Duration: From [Start Date] to [End Date/Ongoing]

Please note that your FMLA entitlement provides up to 12 weeks of unpaid, job-protected leave within a 12-month period. During this time, your health insurance benefits will be maintained under the same conditions as if you had continued to work. You will remain responsible for your portion of the benefit premiums.

You are required to follow standard call-in procedures for any absences. If the dates of your leave change or if you require an extension, you must notify [Department Name/Supervisor] as soon as possible.

Prior to returning to work from leave for your own health condition, you may be required to present a fitness-for-duty certification from your healthcare provider.

If you have any questions regarding your leave or benefits, please contact [HR Contact Name] at [Phone Number/Email].

Sincerely,

[Your Name]

[Your Title]

[Company Name]