# City and County of San Francisco

Intermittent Leave Verification

**FMLA 1E**

Date: _____

To: _____
Employee Name

From: _____
Department Representative

The Certification of Health Care Provider (FMLA 2) form submitted on _____ indicates that it will be necessary for you to work intermittently, or to work on a less than full-time schedule as a result of an FMLA-covered condition. In general, employees who need to use FMLA leave intermittently, or on a reduced leave schedule, must attempt to schedule the leave so as not to disrupt the department's operations.

This letter confirms that you will be working the schedule attached to this letter from (dates): _____ through _____.

This letter confirms that on any occasion you miss work due to the serious health condition which was covered by the Certification of Health Care Provider form submitted on _____, the City will count the absence against your FMLA leave.

**Please notify your supervisor if any other absence is due to the serious health condition covered by your Certification of Health Care Provider (FMLA 2) form, or any other serious health condition, in order to ensure that your absences are counted as FMLA and that your entitlements under the FMLA are observed.**

_____ _____
Department Representative Signature Date

Attachment: Schedule
cc: Personnel File