CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
SCHEDULE FOR REDUCED/INTERMITTENT LEAVE

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____
Employee Address City State Zip Code

SECTION I - EMPLOYEE'S CURRENT SCHEDULE

SHIFT Begins _____ am/pm Off-days _____

Ends _____ am/pm _____

Describe in detail if non-standard shift:

_____

_____

SECTION I I - REDUCED/INTERMITTENT LEAVE SCHEDULE

NOTE: Attach a completed Certification of Health Care Provider, Form WH-380, explaining the medical necessity for the reduced schedule or intermittent leave.

The employee's current work schedule will be changed during the applicable FMLA period to a:

☐ Reduced leave schedule from _____/_____/_____ to _____/_____/_____. Describe schedule in detail:

_____

_____

☐ Intermittent leave schedule from _____/_____/_____ to _____/_____/_____. Describe schedule in detail, including hours/days during which FMLA leave will be utilized.

_____

_____

The employee and the Department have mutually agreed on Section II that allows reduced/intermittent leave during the applicable FMLA leave period.

_____ _____/_____/_____
Employee's Signature Date

_____ _____/_____/_____
Supervisor/Department Coordinator Signature Date

Form K