

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

[Date]

To: [Employer Name/Human Resources Department]
[Company Name]
[Address]

RE: RETURN TO WORK AUTHORIZATION

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

To Whom It May Concern,

This letter serves as formal medical authorization for [Patient Name] to return to work following a Short Term Disability leave that began on [Start Date of Leave].

I have evaluated [Patient Name] and have determined that they are medically cleared to resume their professional duties effective **[Return Date]**.

Work Status (Check One):

- ☐ Full Duty: The patient may return to full capacity with no restrictions.
- ☐ Modified Duty: The patient may return with the following restrictions: [List restrictions or "See attached"]. These restrictions are expected to remain in place until [End Date of Restrictions].

If you have any questions regarding this medical clearance, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]