RETURN TO WORK / FITNESS FOR DUTY CERTIFICATION

To: [Employer Name / HR Department]

From: [Healthcare Provider Name]

Date: [Current Date]

Patient Name: [Employee Name]

Date of Birth: [Employee DOB]

This letter serves to certify that I have examined the above-named patient and evaluated their medical condition in relation to their job requirements.

Authorization Status (Check one):

[ ] The employee is fit to return to work full-time without any restrictions, effective: [Date].

[ ] The employee is fit to return to work with the following restrictions, effective: [Date].

Specific Restrictions / Accommodations:

[Describe restrictions such as lifting limits, sitting/standing durations, or reduced hours]

Duration of Restrictions:

These restrictions are expected to be in place until: [End Date or "Permanent"].

Healthcare Provider Signature: _____

Provider Name/Title: [Name and Title]

Clinic Name: [Clinic/Hospital Name]

Phone Number: [Contact Number]