Date: [Date]

To: [Employer Name/Company Name]
Attention: [Contact Person/HR Department]
Address: [Company Address]

Subject: Fitness for Duty Medical Clearance

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

To Whom It May Concern,

I have completed a medical evaluation of the above-named patient to determine their physical readiness to return to work following their recent injury.

Based on my clinical examination and the requirements of the patient's job description, I have reached the following determination:

[ ] Full Release: The patient is cleared to return to their full, unrestricted job duties effective [Date].

[ ] Modified Duty: The patient is cleared to return to work with the following restrictions effective [Date] through [End Date]:

- Lifting/Carrying: [Limit in lbs]
- Standing/Walking: [Limit in hours/minutes]
- Postural Limits (Bending, Reaching, Squatting): [Details]
- Other Restrictions: [Details]

[ ] Not Yet Cleared: The patient is not yet able to return to work. A follow-up evaluation is scheduled for [Date].

Please contact my office at [Phone Number] if you require further clarification regarding these recommendations.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic/Facility Name]
[License Number]