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

Date: [Current Date]

To: [Employer Name/Company Name]
Attn: [Supervisor or HR Department]

RE: RETURN TO WORK CLEARANCE

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

To whom it may concern,

This letter is to certify that [Employee Name] has been under my medical care. I have evaluated the patient and have determined that they are medically cleared to return to work effective **[Date of Return]**.

Work Status (Select One):

[ ] The employee may return to full duty without any restrictions.

[ ] The employee may return to work with the following temporary restrictions until [End Date]:
[List specific restrictions, e.g., no lifting over 10 lbs, frequent breaks, etc.]

If you have any questions regarding this clearance or require further clarification, please contact my office directly.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[License Number]