**DATE:** [Date]

**TO:** [Employer Name/Human Resources Department]
**COMPANY:** [Company Name]
**ADDRESS:** [Company Address]

**RE:** Medical Assessment for [Employee Name]
**DATE OF BIRTH:** [Employee Date of Birth]

To Whom It May Concern,

I am the treating physician for [Employee Name]. This letter is to formally advise you of the employee's current medical status regarding their ability to perform their job duties.

Based on my recent clinical evaluation, [Employee Name] has a medical condition that prevents them from performing the essential functions of their position as [Job Title].

Specifically, the employee is currently restricted from the following activities:

- [Description of physical or mental limitation 1]
- [Description of physical or mental limitation 2]
- [Description of physical or mental limitation 3]

At this time, it is my professional opinion that:

[Select one option below]

- The employee is unable to work in any capacity effective [Start Date] through [End Date/Estimated Return Date].
- The employee requires permanent restrictions that prevent the performance of essential job functions.

I will continue to monitor the patient's progress and will provide updates regarding any changes to their functional capacity or return-to-work status. Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

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