Date: [Date]

To: [Employer Name/Company Name]
From: [Physician Name/Medical Facility]
Subject: Medical Clearance for Return to Work

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

To Whom It May Concern,

I have evaluated [Patient Full Name] regarding their medical condition and recovery. It is my professional opinion that the patient is medically cleared to return to work effective **[Return Date]**.

Work Status (Select One):

- [ ] Return to full duty without restrictions.
- [ ] Return to work with the following temporary restrictions:

Restrictions (if applicable):
[Describe specific limitations, e.g., no lifting over 10 lbs, no prolonged standing, reduced hours, etc.]

These restrictions are expected to remain in place until [End Date for Restrictions].

If you have any questions or require further clarification, please contact my office at [Phone Number].

Sincerely,

[Signature]
[Physician Name, Title]
[Medical License Number]
[Clinic/Hospital Name]