Date: [Date]

To: [Employer Name / Human Resources Department]
Company: [Company Name]
Address: [Company Address]

Subject: Return to Work Clearance for [Patient Name]

Dear [Manager Name or HR Representative],

This letter is to confirm that [Patient Name] has been under my surgical care following a procedure performed on [Date of Surgery].

I have evaluated the patient and determined that they are medically cleared to return to work effective **[Return Date]**.

The patient's return is subject to the following status (check one):

[ ] **Full Duty:** The patient may resume all previous job responsibilities without any restrictions.
[ ] **Modified Duty:** The patient may return with the following temporary restrictions until [End Date of Restrictions]:

- Lifting/Carrying: No more than [Number] lbs.
- Physical Activity: No [Pushing / Pulling / Climbing / Prolonged Standing].
- Schedule: [e.g., Part-time hours or frequent breaks].
- Other: [Specify any other limitations].

I will re-evaluate the patient's progress on [Next Appointment Date] to determine if these restrictions can be lifted.

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

Sincerely,

[Physician Signature]

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