[Doctor's Name/Medical Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Employer Name/HR Department]
Re: Medical Clearance for Light Duty

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

To Whom It May Concern,

I have evaluated [Employee Name] regarding their medical condition and ability to return to work. I have determined that the patient may return to work in a light-duty capacity starting on **[Start Date]**.

The following workplace accommodations and restrictions are required:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Physical Activity:** No [stooping / bending / climbing / squatting / reaching above shoulder].
- **Posture:** Must be allowed to [sit / stand] for [Number] minutes every hour.
- **Working Hours:** Limited to [Number] hours per shift.
- **Other Restrictions:** [Insert specific details here].

These restrictions are expected to remain in effect until **[End Date or Follow-up Appointment Date]**. At that time, the patient will be re-evaluated to determine if they can return to full duty.

Please contact my office at [Phone Number] if you have any questions regarding these medical recommendations.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Medical License Number]