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

[Date]

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

RE: Medical Clearance for Modified Work Schedule

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

To Whom It May Concern,

I am the treating physician for [Patient Name]. This letter serves to confirm that the patient is medically cleared to return to work; however, a modified schedule is required due to their current medical status.

Effective Dates: This modified schedule should begin on [Start Date] and is expected to continue until [End Date/Date of Re-evaluation].

Recommended Schedule:

- Maximum hours per day: [Number]
- Maximum hours per week: [Number]
- Specific shift limitations (if any): [e.g., No night shifts, mandatory 15-minute breaks every 2 hours]
- Frequency: [e.g., Monday, Wednesday, Friday only]

Physical Restrictions:
[List any physical restrictions here, or state "None"].

I will re-evaluate the patient on [Date] to determine if their schedule can be increased or if they can return to full duty. If you have any questions regarding these medical recommendations, please contact my office.

Sincerely,

[Signature of Physician]

[Printed Name of Physician]
[Medical License Number]