Date: [Date]

To: [Employer Name/Company Name]
Attn: [Manager or HR Department]
Re: Return to Work Clearance for [Patient Name]

To Whom It May Concern,

This letter serves to certify that [Patient Name] has been under my care for physical therapy following a [Injury/Surgery/Medical Condition].

Based on the patient's functional progress and current evaluation, I have determined that they are cleared to return to work effective **[Date]** under the following conditions:

Check one:

- [ ] Full Duty: The patient may return to all normal job duties without restrictions.
- [ ] Modified Duty: The patient may return to work with the specific restrictions listed below.

Physical Restrictions (if applicable):

- **Lifting/Carrying:** Limit to [Number] lbs.
- **Postures:** No [kneeling / squatting / crawling / overhead reaching].
- **Duration:** Limit [standing / walking / sitting] to [Number] minutes per hour.
- **Breaks:** Allow for stretching/rest breaks every [Number] hours.

These restrictions are expected to remain in place until [Date of Next Evaluation/Expected Recovery Date].

If you have any questions regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

[Signature]

[Provider Name, PT/DPT]
[Clinic Name]
[Phone Number]
[Email Address]