[Physician Name/Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

To: [Employer Name / Human Resources Department]

RE: Return to Work Evaluation for [Patient Name]
Date of Birth: [Patient DOB]
Date of Injury/Surgery: [Date]

To whom it may concern,

I have evaluated [Patient Name] regarding their orthopedic condition. It is my clinical opinion that the patient may return to work effective **[Start Date]** with the following physical restrictions in place until **[End Date/Follow-up Date]**.

Lifting/Carrying Restrictions:
[ ] No lifting/carrying over [X] lbs.
[ ] No overhead reaching/lifting with [Left/Right/Both] arm(s).
[ ] Limit repetitive lifting to [X] times per hour.

Postural & Movement Restrictions:
[ ] No prolonged standing (limit to [X] minutes per hour).
[ ] No prolonged walking (limit to [X] minutes per hour).
[ ] No climbing ladders or stairs.
[ ] No kneeling, crawling, or squatting.
[ ] No repetitive bending or twisting at the waist/neck.

Upper Extremity Restrictions:
[ ] No forceful gripping or grasping with [Left/Right/Both] hand(s).
[ ] Limit typing/fine motor tasks to [X] minutes per hour.
[ ] Patient must wear [Sling/Splint/Brace] while working.

Additional Instructions:
[ ] Patient requires a sit-stand workstation.
[ ] Patient must be allowed to change positions every [X] minutes.
[ ] Patient is restricted to [X] hours of work per day.

These restrictions are necessary to prevent further injury and facilitate the healing process. I will re-evaluate the patient on [Next Appointment Date] to determine if these restrictions can be modified or lifted.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Medical License Number]