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

[Date]

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

Re: Return to Work Evaluation for [Employee Name]

To Whom It May Concern,

This letter is to confirm that [Employee Name] was under my care following a surgical procedure on [Date of Surgery]. They are cleared to return to work on [Return Date] with the following physical restrictions:

Physical Restrictions:

- **Lifting/Carrying:** No lifting or carrying more than [Number] pounds.
- **Mobility:** No [climbing ladders / prolonged standing / bending / twisting].
- **Movement:** Limited use of [Right/Left Arm/Leg].
- **Work Hours:** Restricted to [Number] hours per day for [Number] weeks.
- **Other:** [Specify any other restrictions, e.g., sedentary work only].

These restrictions are expected to remain in place until [Date of Next Evaluation or End Date]. At that time, I will re-evaluate the patient's status to determine if restrictions can be lifted or modified.

If you have any questions regarding these medical limitations, please contact my office.

Sincerely,

[Doctor Signature]

[Doctor Printed Name]
[Medical License Number]