Date: [Date]

To: [Employer Name/Company Name]
Attn: [Manager or HR Department]
[Company Address]

RE: Return to Work Evaluation for [Patient Name]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

This letter serves to certify that [Patient Name] has been under my cardiac care and is cleared to return to work effective [Date of Return].

Based on the patient's current cardiovascular status, the following physical restrictions are required to ensure a safe transition back to the workplace:

- **Lifting/Carrying:** May not lift or carry more than [Number] pounds.
- **Physical Exertion:** Avoid strenuous activities, including running, climbing ladders, or pushing/pulling heavy objects.
- **Work Duration:** Limited to [Number] hours per day / [Number] days per week.
- **Rest Periods:** Must be allowed a [Number] minute break every [Number] hours to monitor heart rate or fatigue.
- **Environmental Limits:** Avoid exposure to extreme temperatures (excessive heat or cold) and high-stress environments.
- **Other:** [Specific additional restriction]

These restrictions are expected to remain in place until [Date or Next Evaluation Date]. I will re-evaluate the patient's condition at that time to determine if any adjustments are necessary.

If you have any questions or require further clarification regarding these medical limitations, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Cardiology Practice Name]
[Phone Number]