DATE: [Date]

TO: [Employer Name / HR Department]

FROM: [Provider Name/Clinic Name]

RE: Return to Work Evaluation

PATIENT NAME: [Patient Name]

DATE OF BIRTH: [DOB]

To Whom It May Concern,

The above-named patient was evaluated at our occupational medicine clinic on [Date of Exam]. Based on this evaluation, the patient may return to work with the following physical restrictions:

Effective Dates: [Start Date] to [End Date/Follow-up Date]

Physical Restrictions:

- **Lifting/Carrying:** No more than [Number] lbs.
- **Pushing/Pulling:** No more than [Number] lbs. of force.
- **Postural:** No [bending / stooping / squatting / crawling / climbing].
- **Reaching:** No reaching [above shoulder level / overhead].
- **Repetitive Motion:** No repetitive [typing / grasping / wrist motion] with [Left / Right / Both] hand(s).
- **Mobility:** [Sit down work only / Limited standing or walking].

Additional Instructions:

[Insert additional comments or specific accommodations needed here]

The patient is scheduled for a follow-up evaluation on [Date]. We will re-assess the patient's physical capacities at that time.

Sincerely,

[Provider Signature]

[Provider Name, Credentials]
[Clinic Name]
[Phone Number]