Date: [Date]

To: [Employer Name/Company Name]
From: [Physical Therapist Name], PT, DPT
Subject: Return to Work Recommendations

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

This letter serves to clarify the functional status of [Patient Name], who has been receiving physical therapy for [Injury/Condition]. Based on our most recent evaluation on [Date of Last Evaluation], the patient is cleared to return to work on [Return Date] with the following physical restrictions:

- **Lifting/Carrying:** May not lift or carry more than [Number] pounds.
- **Positional Limits:** [e.g., No prolonged standing more than 30 minutes; No overhead reaching; No repetitive squatting].
- **Mobility:** [e.g., Must use a single-point cane; Needs to avoid stairs; Needs frequent 5-minute walking breaks].
- **Work Schedule:** [e.g., Limited to 4-hour shifts; Modified duties only].

These restrictions are expected to remain in place until [Date or Next Re-evaluation Date]. We will continue to monitor the patient's progress and will provide an updated status report following their next assessment.

Please contact our clinic at [Phone Number] if you require further clarification regarding these limitations.

Sincerely,

[Signature]
[Printed Name and Credentials]
[Clinic Name]