Date: [Date]

To: [Employer Name/HR Department]
Company: [Company Name]
Address: [Company Address]

RE: Return to Work Evaluation for [Patient Name]

To Whom It May Concern,

[Patient Name] has been under my neurological care. They may return to work effective [Date] with the following physical restrictions based on their current neurological status:

Work Schedule Restrictions:

- Limit shift duration to [Number] hours per day.
- Frequent rest breaks required (e.g., [Number] minutes every [Number] hours).
- No overnight or graveyard shifts.

Physical and Environmental Restrictions:

- No lifting, carrying, pushing, or pulling more than [Number] pounds.
- Avoid operating heavy machinery or driving commercial vehicles.
- Avoid working at unprotected heights or on ladders.
- Limit screen time/computer use to [Number] hours per day.
- Minimize exposure to [bright lights / loud noises / extreme temperatures].

Mobility Restrictions:

- No prolonged standing; must be allowed to sit for [Number]% of the workday.
- Avoid repetitive bending, twisting, or reaching.

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

If you have any questions or require further clarification, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Neurology Practice Name]
[Phone Number]