Date: [Date]

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

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

To Whom It May Concern,

I am the primary care provider for [Patient Name]. This letter serves to notify you that the patient may return to work effective **[Start Date]**.

Based on my medical evaluation, the patient has the following physical restrictions until **[End Date/Follow-up Date]**:

- **Lifting/Carrying:** May not lift or carry more than [Number] pounds.
- **Postural:** No [bending / stooping / squatting / crawling / climbing].
- **Reaching:** No [overhead reaching / reaching with right arm / reaching with left arm].
- **Standing/Walking:** Limit to [Number] hours per shift, with breaks every [Number] minutes.
- **Sitting:** Limit to [Number] hours per shift, with breaks every [Number] minutes.
- **Other Restrictions:** [Insert any specific hand, wrist, or environmental restrictions].

I expect these restrictions to be [temporary/permanent]. The patient will be re-evaluated on [Date] to determine if these restrictions can be modified or removed.

Please contact my office at [Phone Number] if you have any questions or require further clarification.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic Name]
[Clinic Phone Number]