Date: [Date]

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

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

To Whom It May Concern,

[Patient Name] has been under my care for a gastroenterological condition. The patient is cleared to return to work on [Return Date] with the following physical restrictions and accommodations to ensure continued recovery:

Physical Restrictions:

- No lifting, carrying, pushing, or pulling more than [Number] pounds.
- Limit strenuous physical activity or abdominal straining.
- Avoid prolonged standing; allow for [Number] minutes of sitting every [Number] hours.

Required Accommodations:

- Frequent and immediate access to restroom facilities as needed.
- Permission to keep water and/or small snacks at the workstation to manage symptoms.
- Scheduled breaks for medication administration.

These restrictions are expected to remain in place until [End Date/Follow-up Appointment Date]. We will re-evaluate the patient's status at that time.

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

Sincerely,

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