Date: [Date]

To: [Employer Name/Company Name]
Attn: Human Resources / Supervisor
Address: [Company Address]

Re: Return to Work Evaluation for [Employee Name]

Dear [Name of Contact Person],

I am writing to provide a medical update regarding the status of [Employee Name], who is currently under my care for an ophthalmological condition. It has been determined that the patient may return to work on [Return Date], subject to the following physical restrictions and accommodations:

Visual Limitations:

- [ ] No prolonged screen time or computer work (Limit to [Number] hours per day).
- [ ] Frequent eye breaks required (e.g., 5-minute break every 20 minutes).
- [ ] No operation of heavy machinery or motor vehicles.
- [ ] Restricted use of depth perception-sensitive equipment.
- [ ] Protection from bright lights or glare (may require tinted lenses).

Physical Restrictions:

- [ ] No lifting objects over [Number] pounds to prevent intraocular pressure spikes.
- [ ] No strenuous physical activity or high-impact movements.
- [ ] No bending over at the waist or putting head below the knees.

Duration:

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

If you have any questions regarding these limitations, please contact my office at [Phone Number].

Sincerely,

[Doctor Name, MD/OD]
[Clinic/Practice Name]
[License Number]