

Date: [Date]

To: [Employer Name/Occupational Health Department]

From: [Physician Name/Clinic Name]

Patient Name: [Employee Name]

Date of Birth: [DOB]

Subject: Medical Clearance and Cognitive Restrictions for Return to Nursing Duties

To Whom It May Concern,

[Employee Name] has been under my care for the treatment of a concussion sustained on [Date of Injury]. They are cleared to return to work on [Return Date] with the following cognitive and clinical restrictions to ensure patient safety and provider recovery:

Work Schedule Restrictions:

- Limit shift length to [Number] hours per day.
- No back-to-back shifts or overtime.
- No night shifts or rotating schedules until [Date].

Cognitive and Clinical Restrictions:

- **Frequent Breaks:** Must be allowed a 10-15 minute cognitive rest break every [Number] hours in a quiet area.
- **Screen Time:** Limit continuous use of Electronic Health Records (EHR) or computer monitors to [Number] minutes at a time.
- **Environment:** Minimize exposure to high-stimulation environments (e.g., loud alarms, bright strobe lighting) where possible.
- **Task Management:** No multi-tasking or managing high-acuity/complex patient assignments for the first [Number] shifts.
- **Medication Safety:** A second licensed staff member must double-check all medication calculations and high-alert drug administrations.

Duration:

These restrictions are in effect until [Follow-up Date], at which time the patient will be re-evaluated for a full return to duty. Please contact my office at [Phone Number] if there are any questions regarding these limitations.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]