Date: [Insert Date]

To: [Supervisor Name / Human Resources]

From: [Treating Physician Name/Clinic]

Subject: Return to Work Medical Release - Temporary Cognitive Restrictions

Employee Name: [Employee Full Name]
Date of Birth: [DOB]

To whom it may concern,

This letter serves to certify that [Employee Name] is cleared to return to work at the laboratory effective [Date] with the following temporary cognitive restrictions. These restrictions are intended to ensure workplace safety and the accuracy of laboratory data during the recovery period.

Current Cognitive Restrictions:

- **Work Duration:** Limit shifts to [Number] hours per day. No overtime or on-call duties.
- **Complexity:** Avoid high-complexity diagnostic testing or manual calculations. Tasks should be repetitive or routine in nature.
- **Environment:** Minimize exposure to high-decibel alarms, flickering lights, or crowded lab spaces. Use of noise-canceling headphones is recommended if safe.
- **Screen Time:** Limit continuous computer or microscopy use to [Number] minutes, followed by a [Number] minute break.
- **Memory Aids:** Allow for the use of written checklists and verbal repetition of instructions for all Standard Operating Procedures (SOPs).
- **Safety:** The employee should not handle hazardous chemicals, biological agents, or operate heavy machinery (e.g., centrifuges, autoclaves) without direct supervision.

Duration of Restrictions:

These restrictions are expected to remain in place until [Date] or until the next follow-up evaluation scheduled for [Follow-up Date].

If you have any questions regarding these medical requirements or need further clarification on how they apply to the laboratory setting, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Name]