Date: [Insert Date]

To: [Employer Name/Occupational Health Department]
From: [Treating Provider Name and Credentials]
Subject: Return to Work Clearance with Supervised Cognitive Task Restrictions

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

This letter serves to certify that [Patient Name] is cleared to return to their duties as a Nurse Practitioner effective [Start Date], subject to the specific cognitive restrictions and supervisory requirements outlined below.

Due to ongoing recovery, the patient requires a period of **Supervised Cognitive Task Performance**. For a duration of [Number] weeks, the following accommodations must be met:

- **Clinical Oversight:** All high-acuity clinical decisions, diagnostic interpretations, and treatment plans must be reviewed and co-signed by a supervising clinician.
- **Prescriptive Authority:** Medication orders and prescriptions must be verified by a peer or supervisor prior to transmission.
- **Workload Limits:** Patient volume should be reduced to [Percentage]% of standard productivity to prevent cognitive fatigue.
- **Complex Tasks:** Participation in complex procedures or emergency response protocols should be restricted unless directly assisted by another qualified provider.
- **Environment:** The patient should be provided a quiet workspace for charting and documentation to minimize cognitive distractions.

I will re-evaluate the patient on [Follow-up Date] to determine if these restrictions can be lifted or modified. Should you have any questions regarding these limitations, please contact my office at [Phone Number].

Sincerely,

[Signature of Healthcare Provider]
[Printed Name and Title]
[Clinic/Facility Name]