

Date: [Date]

To: [Employer Name/HR Department]

From: [Provider Name/Clinic Name]

Re: Return to Work Recommendations for [Patient Name]

Dear [Recipient Name],

I am writing to provide updated medical clearance and work restrictions for [Patient Name], who is currently under my care for a medical condition impacting cognitive function. Based on my clinical evaluation, the patient is cleared to return to work effective [Start Date] with the following temporary accommodations and restrictions:

1. Reduced Patient/Client Volume:

The patient is restricted to a reduced workload to manage cognitive fatigue and ensure patient safety. Please limit their daily schedule to no more than [Number] patients per day or [Number]% of their standard volume.

2. Cognitive Accommodations:

To support the patient's recovery, the following supports are required:

- Frequent cognitive breaks (e.g., 10 minutes of quiet rest every 2 hours).
- Extended time for clinical documentation and administrative tasks.
- A quiet workspace with minimal distractions.
- Access to written instructions or checklists for complex tasks.

3. Work Schedule:

The patient is cleared to work [Number] hours per day, not to exceed [Number] hours per week.

4. Duration:

These restrictions are effective until [End Date/Follow-up Date], at which point the patient's progress will be re-evaluated for a potential increase in duties.

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

Sincerely,

[Provider Signature]

[Provider Printed Name and Title]

[License Number]