

Date: [Insert Date]

To: [Employer Name/Company Name]

From: [Physician/Medical Provider Name]

Patient Name: [Insert Employee Name]

Date of Birth: [Insert DOB]

Subject: Clearance for Light Duty Employment

To Whom It May Concern,

I have evaluated [Employee Name] on [Date of Examination] regarding their recovery from [Injury/Illness]. Based on this evaluation, I have determined that the patient is medically cleared to return to work in a "Light Duty" capacity effective [Start Date].

The patient is subject to the following work restrictions until [End Date or Next Review Date]:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Physical Activity:** No prolonged [standing/walking/climbing/bending].
- **Movement:** No use of [left/right] arm or leg for repetitive tasks.
- **Schedule:** Limited to [Number] hours per shift.

The patient should refrain from any activities that exceed these specific limitations to ensure continued recovery. I will re-evaluate the patient's status on [Date of Follow-up Appointment] to determine if these restrictions can be modified or removed.

If you have any questions or require further clarification regarding these restrictions, please contact my office at [Phone Number].

Sincerely,

[Signature of Physician]

[Printed Name of Physician]

[Medical Facility/Clinic Name]

[License Number]