[Clinic Name]
[Clinic Address]
[Phone Number]
[Email/Website]

DATE: [Date]

TO: [Employer Name/Company Name]
RE: Medical Clearance for Return to Work

PATIENT NAME: [Patient First and Last Name]
DATE OF BIRTH: [MM/DD/YYYY]

To Whom It May Concern,

This letter serves as formal notification that [Patient Name] has been evaluated by our clinic. At the time of the evaluation, the patient is asymptomatic and does not exhibit clinical signs of communicable illness.

Based on current medical guidelines and the patient's reported health status, they are cleared to return to their normal work duties effective **[Return Date]**.

Restrictions:
[ ] No restrictions / Full Duty
[ ] Specific restrictions: [List restrictions if any, otherwise leave blank]

If you require further information or have questions regarding this clearance, please contact our office during standard business hours.

Sincerely,

[Physician/Provider Signature]

[Provider Name and Credentials]
[Medical License Number]