

Date: [Date]

To: [Employer Name/Company Name]

From: [Physician Name, MD/DO]

Subject: Medical Clearance for Return to Work

To Whom It May Concern,

This letter serves to certify that my patient, [**Patient Name**] (DOB: [Date of Birth]), was under my care for a diagnosis of COVID-19 starting on [Start Date of Illness].

As of [Date], the patient has met the clinical criteria for recovery and is no longer considered contagious. According to current public health guidelines and my clinical assessment, the patient is cleared to return to work on [**Return Date**].

Work Status:

- [] Full duty with no restrictions.
- [] Limited duty with the following accommodations: [List accommodations if applicable]

If you require any further information or clarification regarding this medical clearance, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]

[Clinic/Facility Name]