Date: [Date]

To: [Employer Name/Human Resources]
Company: [Company Name]
Address: [Company Address]

RE: Clinical Evaluation of Fitness to Work - Post-COVID-19

Patient Name: [Employee Full Name]
Date of Birth: [DOB]
Date of Evaluation: [Date]

To Whom It May Concern,

This letter confirms that I have clinically evaluated [Employee Name] following their recovery from COVID-19. Based on the clinical assessment and current public health guidelines, I have determined the following:

Status (Select one):

- The employee is fit to return to their full duties without restrictions, effective [Date].
- The employee is fit to return to work with the following temporary restrictions/modifications until [Date]: [List restrictions, e.g., reduced hours, no heavy lifting].

The employee has met the necessary criteria for ending isolation and is no longer considered infectious to others in the workplace. No further testing is required for their return to work at this time.

If you require any further clarification regarding these recommendations, please contact my office directly.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]
[Phone Number]