Date: [Insert Date]

To: [Employer Name / Supervisor Name]
Company: [Company Name]
Address: [Company Address]

Subject: Medical Clearance for Return to Work - [Patient Name]

Dear [Recipient Name],

This letter is to certify that [Patient Name] has been under my medical care for the treatment and recovery of COVID-19. After a clinical evaluation, I am clearing the patient to return to their professional duties.

The patient has met the following criteria for returning to the workplace:

- Completion of the recommended isolation period.
- Improvement of respiratory symptoms.
- Absence of fever for at least 24 hours without the use of fever-reducing medication.

Return to Work Date: [Insert Date]

Work Status and Restrictions:
[Option A: The patient may return to full duty without restrictions.]
[Option B: The patient may return with the following accommodations: (e.g., reduced hours, frequent breaks, no heavy lifting) until (Date)].

The patient is no longer considered contagious and does not pose a health risk to colleagues or the public regarding this specific diagnosis.

If you require any further information, please contact my office at [Phone Number].

Sincerely,

[Doctor Signature]
[Doctor Name, Title]
[Medical Practice/Clinic Name]
[License Number]