Date: [Insert Date]

To: [Insert Clinic Manager/Employer Name]
Clinic Name: [Insert Clinic Name]

RE: Fitness for Duty Evaluation
Employee Name: [Insert Employee Name]
Date of Injury: [Insert Date of Injury]
Type of Injury: Musculoskeletal ([e.g., Lower Back Strain, Wrist Sprain])

Dear [Insert Name],

I have evaluated [Insert Employee Name] on [Insert Evaluation Date] regarding their recovery from the musculoskeletal injury noted above. Based on my clinical examination and the requirements of their role as clinic staff, my recommendations are as follows:

[Select One Option]

- **Full Duty:** The employee may return to work with no restrictions, effective [Insert Date]. They are capable of performing all essential job functions, including lifting, bending, and prolonged standing.
- **Modified Duty:** The employee may return to work with the following temporary restrictions from [Start Date] to [End Date]:
    - No lifting/carrying over [Insert Weight] lbs.
    - Limit repetitive [reaching/pulling/pushing].
    - Allow for [Insert Frequency] minute breaks every [Insert Frequency] hours of standing.
    - Sedentary/Administrative duties only.
- **Not Fit for Duty:** The employee is currently unable to return to work. A follow-up evaluation is scheduled for [Insert Date].

Provider Comments:
[Insert additional notes regarding physical therapy or bracing if applicable]

Sincerely,

_____
Physician/Provider Signature

Provider Name: [Insert Printed Name]
Clinic/Facility: [Insert Medical Facility Name]
Phone Number: [Insert Phone Number]