Date: [Date]

To: [Supervisor Name / Human Resources]
Facility Name: [Facility Name]
Department: [Department Name]

Subject: Modified Duty Return to Work - [Patient Care Technician Name]

Dear [Recipient Name],

This letter is to formally notify you that [Patient Care Technician Name] is cleared to return to work on a modified duty basis effective [Start Date].

Based on medical evaluation, the following restrictions apply until [End Date or Follow-up Date]:

- **Lifting/Carrying:** No lifting or carrying more than [Number] pounds.
- **Patient Handling:** No unassisted patient transfers, lifting, or repositioning.
- **Physical Activity:** Limited [bending/stooping/reaching/standing for long periods].
- **Hours:** Restricted to [Number] hours per shift/week.

The technician is capable of performing non-strenuous tasks such as:

- Monitoring and recording vital signs.
- Documenting patient intake and output.
- Stocking supplies and organizing equipment.
- Performing stationary observation (Sitter duty).
- Basic patient hygiene that does not require heavy lifting.

We will re-evaluate these restrictions following the next medical appointment scheduled for [Date]. Please let us know if these accommodations can be met within the department.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Medical Clinic/Office Name]
[Phone Number]