FITNESS FOR DUTY CERTIFICATION

To: [Employer Name/HR Department]

From: [Healthcare Provider Name]

Date: [Current Date]

Patient Name: [Employee Name]

Date of Birth: [Employee DOB]

This letter serves to certify that I have examined the above-named patient to determine their fitness to return to work following a medical leave of absence starting on [Date Leave Commenced].

Based on my clinical evaluation and the requirements of the patient's job description, I have determined the following (check one):

[ ] The employee is fit to return to full duty without restrictions, effective [Date].
[ ] The employee is fit to return to duty with the following restrictions, effective [Date].

Specific Restrictions/Accommodations (if applicable):

[List restrictions here, e.g., lifting limits, standing duration, or reduced hours]

Duration of Restrictions:

These restrictions are expected to be in place until [Date or Next Evaluation Date].

Please contact my office at [Phone Number] if you require further clarification regarding these medical recommendations.

Sincerely,

[Signature of Healthcare Provider]
[Printed Name]
[Medical License Number]
[Clinic/Hospital Name]