Date: [Date]

To: [Recipient Name/Organization]
Address: [Recipient Address]
RE: Physical Capacities Evaluation for [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I have performed a formal physical capacities evaluation for [Patient Name] on [Date of Examination]. Based on my clinical examination and medical history, the following functional limitations and capabilities have been identified:

1. Lifting/Carrying:
The patient can lift/carry up to [Number] lbs: [Never/Occasionally/Frequently].

2. Postural Activities:
- Sitting: Up to [Number] hours in an 8-hour workday.
- Standing: Up to [Number] hours in an 8-hour workday.
- Walking: Up to [Number] hours in an 8-hour workday.

3. Physical Maneuvers:
- Bending/Stooping: [None/Occasional/Frequent]
- Squatting/Kneeling: [None/Occasional/Frequent]
- Reaching Above Shoulder: [None/Occasional/Frequent]
- Fine Manipulation: [None/Occasional/Frequent]

4. Environmental Restrictions:
[List restrictions such as avoiding heavy machinery, heights, or extreme temperatures].

5. Work Status Recommendation:
[ ] The patient may return to full duty with no restrictions.
[ ] The patient may return to work with the restrictions noted above.
[ ] The patient is currently unable to return to work.

These restrictions are expected to remain in effect until [Date/Follow-up Appointment].

Sincerely,

[Doctor Signature]
[Doctor Name, Title]
[Medical Facility Name]
[Phone Number]