

Date: [Insert Date]

To: [Supervisor Name or HR Department]

Company: [Company Name]

Address: [Company Address]

Subject: Restricted Duty Accommodation Recommendation for [Employee Name]

Dear [Recipient Name],

I am writing to provide a formal recommendation regarding the work status and necessary accommodations for [Employee Name]. Based on a recent medical evaluation, it has been determined that the employee is currently experiencing [Briefly mention condition type, e.g., a physical injury or medical recovery] that necessitates temporary work restrictions.

Effective Dates:

These restrictions are effective as of [Start Date] and are expected to remain in place until [End Date/Date of Re-evaluation].

Recommended Restrictions:

- [Restriction 1: e.g., No lifting objects over 10 lbs]
- [Restriction 2: e.g., No prolonged standing or walking for more than 30 minutes]
- [Restriction 3: e.g., Limited use of right hand/arm for repetitive tasks]
- [Restriction 4: e.g., Frequent breaks required for stretching or medication]

Suggested Accommodations:

To ensure the employee can continue to contribute safely to the workplace, I recommend the following adjustments:

- [Accommodation 1: e.g., Modified workstation or ergonomic chair]
- [Accommodation 2: e.g., Temporary reassignment to administrative or sedentary tasks]
- [Accommodation 3: e.g., Reduction in daily working hours or flexible scheduling]

I believe that with these accommodations, [Employee Name] will be able to perform the essential functions of their role without risk of further injury or aggravation of their condition.

Please contact my office at [Phone Number] or [Email Address] if you require further clarification or additional medical documentation.

Sincerely,

[Signature]

[Physician/Provider Name]

[Title/Medical Practice Name]