

[Doctor's Name/Medical Facility Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To Whom It May Concern,

RE: [Patient Name]
Date of Birth: [DOB]
Date of Surgery: [Date]

This letter is to confirm that [Patient Name] is currently under my care following a [Type of Surgery] procedure performed on [Date].

Regarding the patient's capability to return to work, please note the following status:

Current Status:

- The patient is currently unable to work. They are expected to be cleared to return on [Date].
- The patient may return to work as of [Date] with the restrictions listed below.
- The patient may return to work with full duties, no restrictions, as of [Date].

Work Restrictions (if applicable):

- Sedentary/Desk work only.
- Lifting restriction: No more than [Number] lbs.
- No prolonged standing or walking (maximum [Number] minutes per hour).
- Reduced work schedule: [Number] hours per day.
- Frequent breaks required for: [Reason, e.g., medication, stretching, wound care].

These restrictions are expected to remain in place until [Date], at which time the patient will be re-evaluated.

If you require any further information or clarification regarding these medical recommendations, please contact my office.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Medical License Number]