

Date: [Insert Date]

To: [Employer Name/Company Name]

Department: [Insert Department]

Address: [Insert Address]

Subject: Full Capacity Return to Work Clearance

Dear [Manager Name or HR Representative],

This letter is to formally certify that I have medically evaluated [**Patient Name**] regarding their recovery from [Injury/Illness].

Based on my clinical assessment, the patient has reached maximum medical improvement and is cleared to return to work in a full-time capacity, effective [**Start Date**].

The patient is cleared for all regular duties associated with their position, including but not limited to:

- Full physical activity and lifting requirements.
- Standard operating hours and overtime if applicable.
- Operating heavy machinery or equipment.

There are no medical restrictions or workplace accommodations required at this time. The patient is capable of performing all essential job functions without limitations.

If you require any further information or clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[Medical Facility/Clinic Name]

[License Number]