Date: [Insert Date]

To: [Employer Name / HR Department]
From: [Physician Name, MD/DO]
Re: Physician Clearance and Phased Return to Work Schedule

Patient Name: [Employee Full Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter serves as formal medical clearance for [Employee Full Name] to return to work following a medical leave of absence starting on [Date].

Based on my clinical evaluation, the patient is cleared to return to duty with a **phased approach** to ensure a safe transition. Please find the recommended schedule and restrictions below:

Phased Return Schedule:

- **Phase 1 ([Start Date] to [End Date]):** [Number] hours per day, [Number] days per week.
- **Phase 2 ([Start Date] to [End Date]):** [Number] hours per day, [Number] days per week.
- **Phase 3 ([Start Date]):** Full-time hours with no hourly restrictions.

Specific Work Restrictions & Accommodations:

- [Restriction 1: e.g., No lifting over 10 lbs]
- [Restriction 2: e.g., Must be allowed to sit for 10 minutes every hour]
- [Restriction 3: e.g., Limited use of computer/screen time]

These restrictions shall remain in effect until [Date of Next Evaluation]. At that time, I will reassess the patient's progress to determine if further accommodations are necessary.

If you have any questions or require further clarification regarding these medical recommendations, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical Facility Name]
[Address]
[Phone Number]