Date: [Date]

To: [Employer Name/HR Department Name]
Company: [Company Name]
Address: [Company Address]

RE: Return to Work Clearance for [Patient Name]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am the treating psychiatrist for [Patient Name], who has been under my care for a medical leave of absence since [Start Date of Leave].

I have evaluated [Patient Name] and have determined that they are cleared to return to work effective [Return Date].

Work Status (Select One):

- The patient may return to full duty without restrictions.
- The patient may return to work with the following temporary restrictions/accommodations: [List restrictions, e.g., reduced hours, modified schedule, or specific tasks] until [End Date for Restrictions].

In my clinical opinion, [Patient Name] is capable of performing the essential functions of their position at this time.

Should you require any further clarification regarding this medical clearance, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Psychiatry License Number]
[Clinic/Hospital Name]
[Contact Information]