

[Doctor or Medical Professional Name]
[Professional Title/Specialty]
[Clinic or Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Employer Name or Human Resources Department]
[Organization Name]
[Address]
[City, State, Zip Code]

RE: Notice of Fitness to Return to Medical Duties

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

To Whom It May Concern,

I have been treating [Patient Name] since [Date Treatment Commenced] for a medical condition that required a period of absence from work. I have performed a comprehensive clinical evaluation of the patient on [Date of Evaluation].

Based on this assessment, I am pleased to confirm that [Patient Name] has recovered sufficiently to resume their professional medical duties. The patient is medically fit to return to work effective [Return Date].

Work Status (Select One):

- Full Duty: The patient may return to all previous clinical and administrative responsibilities without any restrictions.
- Restricted Duty: The patient may return to work with the following specific limitations: [List Restrictions/Accommodations] until [End Date for Restrictions].

I have reviewed the physical and cognitive requirements of the patient's role and have determined they are capable of maintaining patient safety and performing their assigned tasks.

Should you require any further clarification or clinical documentation regarding this transition, please do not hesitate to contact my office.

Sincerely,

[Signature]

[Printed Name of Medical Professional]
[License Number/NPI Number]