

[Physician Name/Clinic Name]

[Address]

[Phone Number]

[Date]

RE: RETURN TO WORK CLEARANCE

To [Employer Name/HR Department],

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

This letter serves to confirm that the above-named patient has been under my care following a prolonged hospitalization from [Admission Date] to [Discharge Date].

After a clinical evaluation, I have determined that the patient is medically cleared to return to work effective [Return Date].

Work Status (Check one):

The patient may return to full duty without restrictions.

The patient may return to work with the following temporary restrictions until [End Date]:
[List specific restrictions, e.g., lifting limits, reduced hours, or frequent breaks]

If you require any further information regarding this medical clearance, please contact my office directly.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]