Date: [Date]

To: [Supervisor Name / Human Resources Department]
Organization: [Hospital/Clinic Name]

RE: Modified Clinical Duty Return to Work
Employee Name: [Employee Full Name]
Date of Birth: [Employee DOB]

To whom it may concern,

This letter serves to confirm that [Employee Name] has been under my medical care following a prolonged hospitalization. I have cleared the employee to return to clinical duties on [Start Date], subject to the following modified duty restrictions to ensure a safe transition back to the workplace.

Duration of Restrictions: These modifications are recommended from [Start Date] through [End Date], at which point the employee will be re-evaluated for full duty.

Specific Restrictions/Modifications:

- **Shift Duration:** Limit shifts to no more than [Number] hours per day.
- **Physical Activity:** No heavy lifting over [Number] pounds; minimize prolonged standing or walking.
- **Clinical Volume:** Reduced patient load to [Percentage]% of standard productivity.
- **Rest Periods:** Allow for [Number] minute breaks every [Number] hours.
- **Call Duty:** No overnight call or 24-hour shifts during this period.

Please contact my office at [Phone Number] if you require further clarification regarding these medical recommendations.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical Specialty]
[License Number]