Date: [Insert Date]

To: [Supervisor Name / Occupational Health Department]
From: [Physician Name / Medical Facility]
Subject: Return to Work Clearance with Restricted Patient Care

Patient Name: [Employee Full Name]
Employee ID: [Insert ID Number]
Date of Birth: [Insert DOB]

To Whom It May Concern,

This letter serves to confirm that [Employee Name] has been under my care following a prolonged hospitalization from [Start Date] to [End Date]. The patient is now medically cleared to return to their professional duties effective [Return Date], subject to the specific restrictions and accommodations outlined below.

Due to the extended nature of their recovery, the following limitations regarding direct patient care must be observed for a duration of [Number] weeks/months:

- **Physical Exertion:** No lifting, pulling, or pushing of patients exceeding [Number] lbs.
- **Direct Contact:** Limited bedside patient care to no more than [Number] hours per shift.
- **Environment:** No assignment to high-acuity areas (e.g., ICU, Emergency Department) or isolation rooms.
- **Schedule:** Restricted to [Number] hours per week with no double shifts or mandatory overtime.
- **Support:** Access to a seated workstation for charting and administrative tasks is required.

We will re-evaluate these restrictions on [Follow-up Date] to determine if the patient can return to full, unrestricted duties. Please contact my office at [Phone Number] if you require further clarification regarding these medical limitations.

Respectfully,

[Signature]

[Physician Name, Title]
[Medical License Number]
[Facility Name]