

Date: [Date]

To: [Employer Name/Company Name]

From: [Doctor's Name/Medical Facility]

Subject: Post-Surgical Evaluation and Return to Work Authorization

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Dear [Manager or HR Representative Name],

This letter serves as formal notification that [Patient Name] has undergone a comprehensive post-surgical evaluation following a prolonged hospitalization from [Start Date] to [End Date].

Based on the clinical assessment, the patient is cleared to return to work on [Return Date] under the following conditions:

Status (Check one):

Full Duty: The patient may resume all previous job responsibilities without restrictions.

Modified Duty: The patient may return with the following limitations until [End Date of Restrictions]:

- [Limit on lifting/carrying weight]
- [Requirement for frequent breaks or sitting/standing]
- [Reduced working hours per day/week]
- [Other specific medical restriction]

The patient is scheduled for a follow-up appointment on [Follow-up Date] to reassess their progress and update their work status if necessary.

If you have any questions regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]

[Medical License Number]

[Clinic/Hospital Stamp]