Date: [Date]

To: [Employer Name/Company Name]
Attn: [HR Department/Supervisor Name]
Address: [Company Address]

Re: Return to Work Medical Clearance

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

To Whom It May Concern,

This letter serves to confirm that [Patient Name] has been medically cleared to return to work following their recent surgical procedure, effective [Return Date].

This clearance is granted with the following status (check one):

[ ] Full Duty (No restrictions)
[ ] Modified Duty (Restrictions listed below)

Work Restrictions (if applicable):
[List specific restrictions, e.g., no lifting over 10 lbs, no prolonged standing, sedentary work only, etc.]

These restrictions shall remain in place until [End Date/Next Evaluation Date].

Outpatient Therapy Requirements:
The patient is currently enrolled in outpatient therapy (Physical/Occupational Therapy). Please allow the patient to attend scheduled appointments [Number] times per week to ensure continued recovery and safety in the workplace.

Should you have any questions or require further medical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]
[Contact Information]