Date: [Date]

To: [Employer Name/HR Department]
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Injury/Surgery: [Date]

To Whom It May Concern,

[Patient Name] is currently under the orthopedic care of this clinic for [Diagnosis/Condition]. The patient is cleared to return to work on [Start Date] with the following status:

Work Status:

- [ ] Full Duty - No restrictions.
- [ ] Modified Duty - Subject to the restrictions listed below.

Physical Restrictions (if applicable):

- Lifting/Carrying: No more than [Number] lbs.
- Pushing/Pulling: No more than [Number] lbs.
- Reach: [Limited/No overhead reaching/etc.]
- Mobility: [No prolonged standing/walking/crawling/etc.]

Outpatient Therapy Requirements:

The patient has been referred for outpatient [Physical/Occupational] therapy. It is medically necessary for the patient to attend sessions [Number] times per week for [Number] weeks. We request that the employer allow for flexible scheduling or excused absences to accommodate these essential rehabilitation appointments.

Duration:

These restrictions and therapy requirements are in effect until [Follow-up Date or "Further Notice"]. The patient will be re-evaluated at that time to determine further progression.

Please contact our office at [Phone Number] if you require further clarification.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Clinic Name]