Date: [Date]

To: [Employer Name/Human Resources]

Company: [Company Name]

Re: Return to Work Evaluation for [Patient Name]
Date of Birth: [DOB]

To Whom It May Concern,

I have evaluated [Patient Name] regarding their recent [injury/illness]. Based on my clinical assessment, the patient is cleared to return to work on [Start Date] with specific medical restrictions. These restrictions are necessary while the patient undergoes outpatient therapy to ensure a safe transition back to full duties.

Work Status: Restricted/Modified Duty

Required Restrictions:

- [Insert restriction e.g., No lifting over 10 lbs]
- [Insert restriction e.g., Limited standing to 2 hours per day]
- [Insert restriction e.g., No repetitive reaching with right arm]

Outpatient Therapy Requirements:

- The patient is prescribed [Physical/Occupational/Speech] therapy [Number] times per week.
- The patient will require time off or a flexible schedule to attend these sessions.

These restrictions shall remain in effect until [Date of Next Evaluation or End Date]. At that time, I will re-evaluate the patient's progress in therapy to determine if restrictions can be lifted or modified.

Please contact my office at [Phone Number] if you have any questions regarding these limitations.

Sincerely,

[Physician Name, MD/DO]
[Clinic/Practice Name]
[License Number]