[Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

To: [Employer Name / Human Resources Department]

RE: RETURN TO WORK MEDICAL RESTRICTIONS

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Evaluation: [Date]

To Whom It May Concern,

The above-named patient has been under my medical care. It has been determined that the patient may return to work on **[Return Date]** with the following functional limitations and restrictions:

Work Status:
[ ] Full duties, no restrictions.
[ ] Modified duties as specified below.

Physical Restrictions:
- Lifting/Carrying: No more than [Number] lbs.
- Pushing/Pulling: No more than [Number] lbs.
- Posture: No prolonged [standing / sitting / bending / reaching].
- Movement: No [climbing / squatting / repetitive use of right hand / left hand].

Scheduling Restrictions:
- Maximum hours per day: [Number]
- Frequent breaks required: [Details]

Duration:
These restrictions are in effect until [Date] or until the patient is re-evaluated on [Follow-up Date].

The patient is expected to be able to resume full, unrestricted duties on [Expected Full Return Date].

If you have any questions regarding these medical requirements, please contact our office.

Sincerely,

[Doctor Signature]

[Doctor Name, Credentials]
[Medical License Number]