Date: [Insert Date]

To: [Employee Name]
Employee ID: [Insert ID Number]

Subject: Clearance to Return to Work with Medication Caution

Dear [Employee Name],

Following the review of your medical documentation provided by [Name of Healthcare Provider], we are pleased to confirm that you are cleared to return to work effective [Start Date].

We acknowledge that you are currently prescribed medication as part of your treatment plan. While you are cleared for duty, please adhere to the following safety requirements:

- **Safety Compliance:** You must strictly follow the dosage and timing instructions provided by your physician.
- **Performance & Safety:** If you experience side effects such as drowsiness, dizziness, or blurred vision that may impair your ability to perform your tasks safely, you must notify your supervisor immediately.
- **Work Restrictions:** Based on your current medication, the following restrictions apply: [Insert specific restrictions, e.g., No operating heavy machinery / No driving company vehicles / None].

Your health and safety, as well as the safety of your colleagues, remain our priority. Please sign below to acknowledge that you understand these conditions and will report any changes in your ability to work safely.

Welcome back to the team.

Sincerely,

[Your Name]
[Your Title]
[Company Name]

Employee Acknowledgment:

Signature: _____ Date: _____