

Date: [Date]

To: [Employer Name/Company Name]

From: [Doctor Name, Title]

Subject: Return to Work Authorization - [Patient Name]

Dear [Manager Name or Human Resources],

This letter is to certify that [Patient Name] is cleared to return to work on [Return Date] following a surgical procedure on [Date of Surgery].

The patient is currently utilizing crutches for mobility. To ensure a safe transition back to the workplace, the following restrictions and accommodations are required until [End Date or "Next Evaluation"]:

- Patient must use crutches at all times while walking or standing.
- Limit standing or walking to [Number] minutes per hour.
- Provide a sedentary (seated) workstation if possible.
- Allow for leg elevation of [Height] for [Duration] throughout the day.
- Ensure a clear path of travel free of stairs or floor obstructions.
- Prohibit lifting, carrying, or pushing/pulling loads over [Number] lbs.

I will re-evaluate the patient's progress on [Date of Follow-up Appointment] to determine if these restrictions can be lifted. Please contact my office at [Phone Number] if you have any questions regarding these medical requirements.

Sincerely,

[Doctor Signature]

[Doctor Printed Name]

[Medical Clinic/Hospital Name]