[Physician Name/Clinic Name]
[Address]
[Phone Number]

Date: [Date]

To: [Employer Name/Human Resources]

Subject: Return to Work Evaluation for [Employee Name]

To Whom It May Concern,

This letter serves to certify that [Employee Name] is cleared to return to work effective [Start Date].

Due to a medical necessity, the employee is required to wear an orthopedic brace ([Type of Brace, e.g., knee, wrist, back]) while performing their professional duties. This assistive device is required for:

- [ ] Full-time use during work hours.
- [ ] Use only during specific activities: [List activities].

Work Restrictions and Accommodations:

- The employee must wear the brace at all times as prescribed.
- [List any specific limitations, e.g., No lifting over 10lbs, no prolonged standing, or frequent breaks].
- The brace must be allowed to fit under or over clothing/uniforms as necessary for function.

The estimated duration for the use of this assistive device is [Number of Weeks/Months] or until the follow-up evaluation scheduled for [Follow-up Date].

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]