

**Date:** [Insert Date]

**To:** [Employer Name / Human Resources Department]

**Company:** [Company Name]

**Address:** [Company Address]

**RE: Medical Clearance for Motorized Scooter Use**

**Patient Name:** [Employee Full Name]

**Date of Birth:** [Employee DOB]

To Whom It May Concern,

I am writing to provide medical clearance for [Employee Name] to return to work effective [Return Date].

Due to [briefly state medical necessity, e.g., mobility limitations], it is medically recommended that the patient utilizes a motorized scooter to perform their professional duties and navigate the workplace efficiently. I have evaluated the patient and determined they are physically and cognitively capable of operating this device safely within an office or industrial environment.

**Recommended Accommodations:**

- Authorization to operate a motorized scooter during work hours.
- Access to elevators and ADA-compliant entryways.
- Designated space for scooter parking and battery charging.
- [Insert any additional specific restrictions or requirements here].

The patient is cleared to perform their regular job functions with the aid of this mobility device. These recommendations are expected to remain in place until [Expected End Date or "Indefinitely"].

If you require further information or clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice/Clinic Name]

[Medical License Number]