[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Employer Name/Human Resources]
[Company Name]
[Address]

Re: Return to Work Evaluation for [Patient Name]

To Whom It May Concern,

This letter serves to certify that [Patient Name] has been under my medical care and is cleared to return to work as a Medical Assistant effective [Date].

The patient may return to full-time duties with the following temporary physical restriction:

- **Heavy Lifting Restriction:** The patient is restricted from lifting, carrying, pushing, or pulling more than [Number] pounds.

This restriction specifically includes tasks such as assisting with patient transfers, moving heavy medical equipment, or lifting heavy supply boxes. These restrictions are expected to remain in place until [Date or Next Evaluation Date].

All other standard Medical Assistant duties, including clinical charting, vitals, and administrative tasks, may be performed as usual.

Please contact my office if you have any questions regarding these limitations.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]