

Date: [Date]

To: [Employer Name/Company Name]

From: [Physician Name], [Clinic Name]

Subject: Return to Work Medical Release

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

To Whom It May Concern,

This letter is to certify that [Patient Name] has been under my medical care. The patient may return to work effective [Start Date] with the following physical restrictions:

- **Lifting Restriction:** The patient is restricted from lifting, carrying, pushing, or pulling more than [Number] pounds.
- **Duration:** These restrictions are expected to remain in place until [End Date or "Next Evaluation"].
- **Other Restrictions:** [Insert any additional notes or "None"].

Please ensure that the patient's duties are adjusted to accommodate these medical requirements. If modified duty is unavailable, the patient should remain off work until the restrictions are lifted.

If you have any questions or require further clarification, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic Name]

[Clinic Address]