

Date: [Insert Date]

To: [Manager Name / HR Department]

Company: [Company Name]

Subject: Return to Work Clearance and Lifting Restrictions

Employee Name: [Employee Name]

Employee ID: [Employee ID/Payroll Number]

Dear [Manager Name],

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

Based on a recent occupational health assessment, the following physical restrictions apply to ensure a safe return to duties:

- **Lifting Restriction:** The employee must not lift, carry, push, or pull any objects weighing more than [Insert Weight, e.g., 10 lbs / 5 kg].
- **Duration:** These restrictions are in place until [Insert Date] and will be reviewed on [Date of Next Evaluation].
- **Specific Movements:** [Optional: Avoid repetitive bending, twisting, or overhead lifting].

Please ensure that the employee's workstation and daily tasks are adjusted to comply with these safety requirements. If reasonable accommodations cannot be met within their current role, please contact the Occupational Health department to discuss alternative duties.

A follow-up appointment has been scheduled for [Date]. We will provide an updated status report following that assessment.

Sincerely,

[Your Name/Signature]

[Title/Professional Designation]

[Occupational Health Department/Clinic Name]