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

[Date]

To: [Employer Name/Human Resources Department]
Regarding: [Employee Name]
Date of Birth: [Employee DOB]

To Whom It May Concern,

This letter serves to confirm that [Employee Name] has been under my care following a surgical procedure performed on [Date of Surgery].

The patient is cleared to return to work effective [Return Date] with the following medical restrictions regarding physical activity:

- **Weight Limit:** The patient must not lift, carry, push, or pull more than [Number] pounds.
- **Duration:** These lifting restrictions remain in place until [Date or Next Evaluation].
- **Additional Constraints:** [Optional: e.g., No repetitive bending, twisting, or reaching].

We will re-evaluate the patient's physical capabilities on [Next Appointment Date] to determine if these restrictions can be modified or lifted. Please provide the necessary accommodations to ensure the patient's safety and recovery.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]