

Date: [Date]

To: [Employer Name/Company Name]

Re: [Patient Name]

Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

[Patient Name] has been under my orthopedic care for [Injury/Condition]. It has been determined that the patient may return to work effective [**Start Date**] with the following medical restrictions:

Lifting Restrictions:

- The patient is restricted from lifting, carrying, pushing, or pulling more than [**Number**] pounds.
- The patient should avoid frequent bending, twisting, or reaching overhead.

Additional Accommodations:

- [Insert specific instructions such as: Must be allowed to sit/stand as needed]
- [Insert specific instructions such as: Limit use of affected limb]

These restrictions are expected to remain in place until [**End Date or Follow-up Appointment Date**], at which time the patient's progress will be re-evaluated.

Please contact my office at [Phone Number] if you require further clarification regarding these limitations.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Hospital Name]

[Address]

[Phone Number]