Date: [Date]

To: [Employer Name / Human Resources]

Company: [Company Name]

Address: [Company Address]

RE: Return to Work Medical Authorization

Employee Name: [Employee Full Name]

Date of Birth: [Employee DOB]

To Whom It May Concern,

I have evaluated [Employee Name] and have determined that they may return to work effective [Start Date].

However, the patient is restricted from performing any heavy lifting. Please adhere to the following specific limitations:

- **Maximum Lifting Weight:** Not to exceed [Number] pounds.
- **Frequency:** [Occasional / Frequent / Never]
- **Duration of Restrictions:** These restrictions remain in effect until [End Date or Next Evaluation Date].

All other job duties may be performed as long as they do not violate the lifting limit stated above. If light-duty work or modified tasks are not available, please contact my office.

Sincerely,

[Physician Signature]

Physician Name: [Printed Name]

Medical Clinic/Facility: [Clinic Name]

Phone Number: [Phone Number]