Date: [Date]

To: [Employer Name/Company Name]
From: [Physical Therapist Name, Credentials]
Facility: [Clinic Name]

RE: Return to Work Status for [Patient Name]

To Whom It May Concern,

[Patient Name] has been under my care for physical therapy since [Date]. Based on their clinical progress and functional capacity evaluation, I am clearing the patient to return to work on [Return Date] with the following medical restrictions.

Physical Restrictions:

- **Lifting Limit:** Do not lift, carry, push, or pull more than [Number] pounds.
- **Frequency:** Lifting should be [Occasional/Rare] and not exceed [Number] repetitions per hour.
- **Technique:** Avoid lifting from the floor level; all lifting should occur between waist and shoulder height.
- **Other:** [Optional: e.g., No overhead reaching, avoid prolonged bending].

Duration:

These heavy lifting restrictions are in effect until [Date] or until the patient is re-evaluated on [Next Appointment Date].

If you have any questions regarding these limitations or require further clarification on the patient's physical capabilities, please contact our office at [Phone Number].

Sincerely,

[Signature]
[Physical Therapist Name]
[License Number]