Date: [Date]

To: [Employer Name/HR Department]
From: [Physician Name, Degree]
Clinic: [Clinic Name]
Phone: [Phone Number]

Re: Return to Work Evaluation for [Patient Name]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation]. Based on my medical assessment, the patient is cleared to return to work on [Return Date] with the following physical restrictions regarding heavy lifting:

Lifting Restrictions:

- The patient may not lift, carry, push, or pull more than [Number] pounds.
- This restriction applies to: [Check all that apply: Occasional lifting / Frequent lifting / Continuous lifting].
- The patient should avoid repetitive [bending/twisting] while handling loads.

Duration:

These restrictions are expected to remain in place until [Date or Next Appointment Date]. I will re-evaluate the patient at that time to determine if the restrictions can be modified or lifted.

All other work activities may be performed as usual, provided they do not exceed the weight limit specified above.

Please contact my office if you have any questions or require further clarification.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[License Number]