Date: [Date]

To: [Employer Name / Occupational Health Department]
Company: [Healthcare Facility/Clinic Name]
Address: [Company Address]

RE: Medical Clearance and Activity Restrictions
Employee Name: [Employee Full Name]
Date of Birth: [Date of Birth]

Dear [Contact Person or Department],

I am the treating healthcare provider for [Employee Name]. The patient is currently under my care for a medical condition that requires specific workplace accommodations regarding their duties as a Phlebotomist.

Effective [Start Date] through [End Date/Until Further Notice], the patient is cleared to perform their regular duties with the following **prolonged standing restriction**:

- The patient must not stand for more than [Number] minutes/hours consecutively.
- The patient requires a [Number]-minute seated break for every [Number] minutes of standing.
- The patient must be allowed to use a tall stool or "perch" chair while performing blood draws and specimen processing.
- The patient should avoid stationary standing and be allowed to walk or change positions as needed.

These restrictions are medically necessary to prevent the aggravation of the patient's condition. All other job functions that can be performed while seated or with intermittent movement remain within the patient's functional capacity.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP/PA]
[Medical License Number]
[Clinic/Hospital Name]
[Phone Number]