Date: [Insert Date]

To: [Supervisor Name / HR Department]
Clinic Name: [Insert Clinic Name]

Subject: Return to Work Medical Clearance - Restricted Standing

Employee Name: [Insert Employee Name]
Date of Birth: [Insert Date of Birth]

Dear [Recipient Name],

This letter is to certify that [Employee Name] is medically cleared to return to work at [Clinic Name] effective [Start Date].

Due to current medical considerations, the following work restrictions regarding standing and mobility are required:

- **Standing Limitation:** The employee may not stand for more than [Number] minutes at a time.
- **Rest Intervals:** The employee requires a sitting break of [Number] minutes for every [Number] minutes spent standing or walking.
- **Total Standing Time:** Total standing time must not exceed [Number] hours per shift.
- **Equipment:** It is recommended that a stool or chair be provided at the workstation (e.g., reception desk or triage station) to allow for seated performance of duties.
- **Lifting:** The employee should avoid lifting or carrying items over [Number] lbs while standing.

These restrictions are expected to remain in place until [End Date or Next Evaluation Date]. We will re-evaluate the employee's status at that time to determine if standing capacity has improved.

If there are any questions regarding these limitations or if further clarification is needed to assist with workplace accommodations, please contact my office.

Sincerely,

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