Date: [Date]

To: [Employer Name / Human Resources Department]

Employee Name: [Patient Name]

Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

This letter serves to outline the modified duty requirements for the above-named patient due to medical necessity. The patient may return to work effective [Start Date], subject to the following standing and mobility restrictions:

- **Standing/Walking Limit:** The patient is restricted to [Number] minutes of continuous standing or walking.
- **Rest Intervals:** After the period of standing mentioned above, the patient must be allowed to sit for [Number] minutes before resuming standing duties.
- **Daily Maximum:** Total standing/walking time should not exceed [Number] hours per 8-hour shift.
- **Equipment:** It is recommended that a stool or chair be provided at the patient's workstation to allow for intermittent rest.
- **Other Restrictions:** [Insert additional restrictions such as no climbing ladders, squatting, or lifting].

These restrictions are expected to remain in place until [End Date/Follow-up Appointment Date]. We will re-evaluate the patient's status at that time to determine if further modifications are required.

Thank you for your cooperation in accommodating these medical restrictions.

Sincerely,

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