Date: [Date]

To: [Employer Name / Human Resources]

Facility: [Clinic/Hospital Name]

RE: Return to Work Evaluation for [Nurse Name, Credentials]

Dear [Manager Name],

This letter serves to confirm that [Nurse Name] is cleared to return to work at the surgical clinic effective [Date].

Upon evaluation, the following medical restrictions regarding standing and mobility are required for a period of [Number] weeks, ending on [End Date]:

- **Standing/Walking Limit:** No more than [Number] hours of total standing or walking per 8-hour shift.
- **Rest Periods:** Must be allowed a [Number]-minute seated break every [Number] hours.
- **Postural Restrictions:** No prolonged static standing in the operating room or at the scrub sink for more than [Number] consecutive minutes.
- **Lifting:** No lifting, pushing, or pulling of equipment or patients exceeding [Number] pounds.

The patient is capable of performing administrative duties, phone triage, or light clinical tasks that allow for seated intervals. We will re-evaluate these restrictions on [Follow-up Date].

If you have any questions regarding these limitations, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic Name/Stamp]