

**Date:** [Insert Date]

**To:** [Supervisor Name / Human Resources Department]

**From:** [Physician Name/Clinic Name]

**Subject:** Medical Release and Work Limitations - [Employee Name]

To Whom It May Concern,

This letter serves to confirm that [Employee Name] has been under my medical care. The patient is cleared to return to work effective [Start Date] with specific safety limitations regarding thermal hazards.

Due to [nature of injury/medical recovery], the employee must strictly adhere to the following restrictions when working with or near autoclaves and high-temperature sterilization equipment:

- **Thermal Exposure:** The employee is restricted from direct exposure to steam, hot surfaces, or ambient temperatures exceeding [Insert Temperature] degrees Fahrenheit.
- **Manual Handling:** No manual handling of hot trays, glassware, or sterilized instruments until [Insert Date or "fully cleared"].
- **Personal Protective Equipment (PPE):** Enhanced thermal protection (heat-resistant gloves, face shields, and aprons) must be worn at all times when operating in the autoclave suite.
- **Proximity:** The employee should maintain a minimum distance of [Insert Distance] from active steam vents or pressure release valves.

These limitations are expected to remain in place until [Expected End Date]. A follow-up evaluation is scheduled for [Follow-up Date] to reassess these restrictions.

If you have any questions or require further clarification regarding these medical requirements, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Medical License Number]

[Clinic/Hospital Stamp]