[Physician Name/Medical Practice]

[Address]

[City, State, Zip Code]

[Phone Number]

Date: [Current Date]

To: [Employer Name / Safety Department]

Subject: Return to Work Clearance - Commercial Driver

Driver Name: [Employee Full Name]

Date of Birth: [DOB]

Date of Injury: [Injury Date]

To Whom It May Concern,

I have medically evaluated the above-named driver regarding the injury sustained on the date listed above. Based on my clinical examination and the physical requirements of a Commercial Driver's License (CDL) holder, I have determined the following:

Status (Select one):

- [ ] **Full Duty:** The driver is cleared to return to full commercial driving duties without restrictions, effective [Date].
- [ ] **Modified Duty:** The driver may return to work with the following restrictions from [Start Date] to [End Date]:
  [List specific restrictions, e.g., no lifting over 20lbs, no driving more than 4 hours, etc.]
- [ ] **Not Cleared:** The driver is currently unable to perform commercial driving duties. A follow-up evaluation is scheduled for [Date].

FMCSA Compliance:

I confirm that the driver continues to meet the physical qualification standards as outlined in 49 CFR 391.41. [Include if applicable: A new Medical Examiner's Certificate (MEC) has been issued.]

If you have any questions regarding this evaluation, please contact my office.

Sincerely,

_____
[Physician Signature]

[Physician Printed Name]
[Medical License Number / National Registry Number]