Date: [Date]

To: [Employer Name/Company Name]
Attn: [HR Department/Supervisor Name]
Address: [Company Address]

RE: RETURN TO WORK CLEARANCE

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Date of Evaluation: [Evaluation Date]

To Whom It May Concern,

[Patient Name] has been under my neurological care following a [Type of Event/Condition, e.g., concussion, seizure, neurological episode]. Based on a comprehensive neurological evaluation conducted on [Date], I am providing the following medical clearance regarding their return to work.

Work Status (Select One):

- The patient is cleared to return to full duty without restrictions effective [Start Date].
- The patient is cleared to return to work with the following restrictions effective [Start Date]:

Functional Restrictions (If applicable):

[List specific restrictions, e.g., limited screen time, no operating heavy machinery, reduced hours, or frequent breaks.]

Duration of Restrictions:

These restrictions are expected to remain in place until [Date or Follow-up Appointment].

In my clinical opinion, the patient is neurologically stable to perform their job duties within the parameters outlined above. If you have any questions or require further clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Board Certification/Specialty]
[Clinic/Hospital Name]
[Phone Number]