Date: [Date]

To: [Employer Name/Company Name]
Attn: [Manager or HR Department]
Fax/Email: [Contact Information]

RE: Physical Therapy Discharge and Return to Work Clearance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Injury/Surgery Date: [Date]

To Whom It May Concern,

This letter serves to notify you that [Patient Name] has successfully completed their course of physical therapy at [Clinic Name] as of [Discharge Date].

Based on the patient's functional progress and clinical evaluation, they are cleared to return to work effective **[Return Date]** under the following status:

[ ] Full Duty: The patient may return to all previous job responsibilities without restrictions.

[ ] Modified Duty: The patient may return to work with the following temporary restrictions until [Re-evaluation Date]:

- Lifting/Carrying limit: [e.g., 20 lbs]
- Pushing/Pulling limit: [e.g., 50 lbs]
- Positional Restrictions: [e.g., No overhead reaching, no prolonged standing]
- Break Requirements: [e.g., 5-minute stretch break every hour]

The patient has been instructed on a Home Exercise Program (HEP) to maintain their current level of function and prevent re-injury. If you have any questions regarding these recommendations, please contact our office at [Phone Number].

Sincerely,

[Signature]
[Physical Therapist Name, Credentials]
[Clinic Name]