Date: [Insert Date]

To: [Employer Name / Company Name]
Attention: [Safety Department / Human Resources]
Address: [Company Address]

Subject: MEDICAL RELEASE TO RETURN TO DUTY - COMMERCIAL DRIVER

Driver Name: [Insert Driver Full Name]
Date of Birth: [Insert DOB]
Driver's License Number: [Insert CDL Number]

To Whom It May Concern,

I have medically evaluated the above-named individual following their recent [illness/injury/leave of absence] which began on [Start Date].

Based on my clinical examination and a review of the physical requirements for a Commercial Motor Vehicle (CMV) driver as defined by Department of Transportation (DOT) and Federal Motor Carrier Safety Administration (FMCSA) regulations, I find this individual to be:

[ ] Fit for Duty - Full Release: The driver may return to full commercial driving duties and safety-sensitive functions without restrictions effective [Return Date].

[ ] Fit for Duty - With Restrictions: The driver may return to work effective [Date] with the following temporary limitations: [Insert restrictions such as lifting limits, reduced hours, etc.]. These restrictions are expected to remain in place until [End Date].

I further certify that any medications currently prescribed to the driver do not interfere with the safe operation of a commercial motor vehicle.

Sincerely,

[Physician/Medical Examiner Signature]
[Printed Name and Title]
[Medical Registry Number/NRCME ID]
[Clinic Name/Address]
[Phone Number]