Date: [Date]

To: [Employer Name / Contact Person]
Company Name: [Company Name]
Address: [Company Address]

RE: Workers' Compensation Return to Work Clearance

Patient Name: [Patient Name]
Date of Birth: [Date of Birth]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] regarding the injury sustained on the date mentioned above. Based on my clinical findings, the patient is cleared to return to work effective **[Return Date]**.

The patient's return to work status is as follows:

[ ] Full Duty: The patient may return to their previous position with no restrictions.

[ ] Modified Duty: The patient may return to work with the following restrictions until [End Date/Next Evaluation]:

- **Lifting/Carrying:** Maximum [Weight] lbs.
- **Postural Limits:** [e.g., No bending, kneeling, or overhead reaching]
- **Mobility:** [e.g., No prolonged standing or walking]
- **Other:** [List specific restrictions here]

I will re-evaluate the patient's status on [Date of Follow-up Appointment].

If you have any questions regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

[Doctor Name, Credentials]
[Clinic/Facility Name]
[Address]
[Phone Number]

Signature: _____