

Date: [Insert Date]

To: [Employer Name/Company Name]

Attn: [Manager or HR Department Name]

RE: Physical Capacity Clearance for Return to Work

Employee Name: [Insert Employee Name]

Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

I have medically evaluated [Employee Name] on [Date of Evaluation] to assess their physical capacity to return to their employment duties following a period of [Illness/Injury].

Based on my clinical examination, it is my professional opinion that the employee is cleared to return to work effective [**Return Date**] under the following status:

Full Duty: The employee may return to their previous position without any physical restrictions or limitations.

Modified Duty: The employee may return to work with the following physical restrictions until [End Date/Re-evaluation Date]:

- **Lifting/Carrying:** Limited to [Weight] lbs.
- **Postural:** No [Bending/Twisting/Squatting/Climbing].
- **Mobility:** Limited [Walking/Standing] to [Number] hours per shift.
- **Other:** [List any additional restrictions].

Please ensure that the workplace can accommodate these requirements to ensure a safe return to the environment. I will re-evaluate the employee's status on [Date of Next Appointment].

If you require further clarification regarding these physical limitations, please contact my office.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Hospital Name]

[Phone Number]

[Email Address]