MODIFIED DUTY RETURN TO WORK CLEARANCE LETTER

Date: [Date]

To: [Employer Name]
Attention: [Supervisor or HR Department]
Address: [Company Address]

Re: [Employee Name]
Date of Injury/Illness: [Date]

To Whom It May Concern,

I have evaluated [Employee Name] on [Date of Evaluation] and have determined that they may return to work on [Return Date] with the following temporary restrictions and modifications:

Current Restrictions:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Postural:** [e.g., No prolonged standing, no bending, no overhead reaching].
- **Activity:** [e.g., Sedentary work only, limited use of right hand].
- **Schedule:** [e.g., Maximum 4 hours per day, frequent breaks required].

Duration:
These restrictions are expected to remain in place until [Date or Next Evaluation].

Physician's Statement:
The employee is medically cleared to perform work duties that fall within the scope of the limitations listed above. Please provide notification if modified duties are available that accommodate these requirements.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Facility Name]
[Phone Number]