Date: [Insert Date]

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

Subject: Fitness for Duty Medical Clearance

Employee Name: [Insert Employee Name]
Date of Birth: [Insert DOB]
Date of Evaluation: [Insert Date of Exam]

To Whom It May Concern,

I have completed a medical evaluation of the above-named employee to determine their physical and mental readiness to perform the essential functions of their job role as [Insert Job Title].

Based on my clinical examination and a review of the job description provided, my medical opinion is as follows:

Status (Select one):

- [ ] The employee is cleared for full duty without restrictions, effective [Insert Date].
- [ ] The employee is cleared for modified duty with the following restrictions from [Start Date] to [End Date]:
  [List specific restrictions, e.g., lifting limits, standing duration, etc.]
- [ ] The employee is not yet cleared to return to work. A follow-up evaluation is scheduled for [Insert Date].

If modified duty is recommended, I have determined that these restrictions are necessary to ensure the safety of the employee and others in the workplace. I will re-evaluate the employee's status on [Insert Date] to determine if further adjustments are required.

Please contact my office at [Insert Phone Number] if you require further clarification regarding these recommendations.

Sincerely,

[Signature of Medical Provider]
[Printed Name of Medical Provider]
[Title/Credentials]
[Clinic/Medical Facility Name]
[License Number]