

Date: [Date]

To: [Employer Name / Supervisor Name]

Company: [Company Name]

Address: [Company Address]

Subject: Medical Clearance for Return to Work

Employee Name: [Employee Full Name]

Date of Birth: [Employee Date of Birth]

Dear [Recipient Name],

I am writing to confirm that [Employee Name] has been under my medical care since [Date]. After a clinical evaluation, I have determined that the patient is medically cleared to return to their employment duties.

Return to Work Date: [Effective Date]

Status of Clearance (Check one):

- **Full Duty:** The employee may return to work with no physical or medical restrictions.
- **Modified Duty:** The employee may return to work with the following restrictions:
[List specific restrictions, e.g., no lifting over 10lbs, frequent breaks, etc.]

The aforementioned restrictions, if any, are expected to remain in effect until [End Date of Restrictions].

If you require any further information or clarification regarding this medical clearance, please contact my office at [Phone Number].

Sincerely,

Physician Signature: _____

Physician Name: [Print Name]

Medical License #: [License Number]

Facility Name: [Clinic/Hospital Name]

Contact Information: [Email/Phone]