Date: [Date]

To: [Employer Name / Human Resources Department]
Company: [Company Name]
Address: [Company Address]

RE: Physician Authorization for Light Duty Return to Work
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I have evaluated [Patient Name] regarding their medical condition and recovery. It is my professional opinion that the patient is cleared to return to work in a **light duty** capacity effective [Start Date].

The following work restrictions apply through [End Date or Next Evaluation Date]:

- **Lifting/Carrying:** Not to exceed [Number] pounds.
- **Physical Movements:** No [bending, stooping, squatting, or overhead reaching].
- **Postural:** Limit standing/walking to [Number] hours per day. Must be allowed to sit as needed.
- **Other Restrictions:** [Insert any specific limitations regarding machinery, driving, or repetitive motions].

I expect the patient to be able to return to full, unrestricted duty on [Projected Date], pending a follow-up evaluation on [Date].

If these accommodations are not available, the patient should remain off work until their next appointment.

Sincerely,

[Physician Signature]

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