

**Date:** [Date]

**To:** [Employer Name/Company Name]

**Attention:** [Manager or HR Representative Name]

**Address:** [Company Address]

**Subject:** Post-Injury Return to Work Certification

**Patient Name:** [Employee Full Name]

**Date of Injury:** [Date]

To Whom It May Concern,

I have examined [Employee Name] following their injury and have evaluated their fitness to resume work duties.

Based on my clinical evaluation, the employee is cleared to return to work effective **[Return Date]** under the following status:

**Full Duty:** The employee may resume all regular job duties without any physical restrictions.

**Modified Duty:** The employee may return to work with the following restrictions until [End Date/Next Review Date]:

- [Restriction 1, e.g., No lifting over 10 lbs]
- [Restriction 2, e.g., Must remain seated 50% of the shift]
- [Restriction 3, e.g., Limited use of right hand]

I will re-evaluate the employee's status on [Date of Follow-up Appointment]. Please contact my office at [Phone Number] if you have any questions regarding these recommendations.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Medical Facility Name]

[Phone Number]