Date: [Date]

To: [Employer Name / Company Name]
Attn: [HR Department / Manager Name]
Address: [Company Address]

Subject: Fitness for Duty Clearance

Employee Name: [Employee Full Name]
Date of Birth: [Employee DOB]
Date of Evaluation: [Date of Medical Exam]

To Whom It May Concern,

I have completed a medical evaluation of the above-named employee to determine their physical and/or mental fitness to return to work and perform the essential functions of their position as [Job Title].

Based on my clinical findings, I provide the following clearance status:

[ ] Full Clearance: The employee is cleared to return to work at full capacity without any restrictions, effective [Start Date].

[ ] Limited Clearance: The employee is cleared to return to work with the following restrictions/accommodations, effective [Start Date] through [End Date]:
[Insert specific restrictions, e.g., lifting limits, reduced hours, etc.]

[ ] Not Cleared: The employee is not currently fit to resume work duties. A follow-up evaluation is scheduled for [Date].

If you require further clarification regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Full Name and Title]
Medical Facility: [Clinic/Hospital Name]
License Number: [Provider License #]