[Date]

[Employer Name]
[Company Name]
[Company Address]
[City, State, Zip Code]

RE: Return to Work Medical Clearance

To [Recipient Name or Department],

This letter is to certify that [Patient Name] has been under my care following a surgical procedure performed on [Date of Surgery].

I have evaluated the patient and determined that they are medically cleared to return to work effective [Return Date].

Work Status (Select One):

- The patient may return to full duty without any restrictions.
- The patient may return to work with the following temporary restrictions: [List restrictions, e.g., no lifting over 10 lbs, limited standing, etc.]. These restrictions are expected to remain in place until [Date].

Please feel free to contact my office at [Phone Number] if you require any further information or clarification regarding these medical recommendations.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Practice Name]