Date: [Date]

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

RE: RETURN TO WORK MEDICAL CLEARANCE

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Date of Surgery: [Surgery Date]

Dear [Manager Name or HR Representative],

This letter is to certify that [Patient Name] has been under my care following a surgical procedure. I have evaluated the patient and determined their fitness to return to work.

Work Status (Select One):

[ ] The patient is cleared to return to work at **full capacity** with no restrictions effective [Return Date].

[ ] The patient is cleared to return to work with **modified duties** beginning [Return Date] until [End Date/Re-evaluation Date].

Specific Restrictions/Accommodations:

- Lifting limitations: [e.g., No more than 10 lbs]
- Physical activity: [e.g., No prolonged standing, no bending]
- Schedule: [e.g., Part-time hours only]
- Other: [Specify any other requirements]

The patient is scheduled for a follow-up appointment on [Date]. We will provide an updated status report following that visit if necessary.

If you have any questions or require further clarification regarding these medical recommendations, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical Practice Name]
[Address]
[Phone Number]