Date: [Date]

To: [Employer Name / Organization Name]
From: [Physician Name, Title]
Facility: [Medical Practice/Hospital Name]

RE: Return to Work Clearance for [Patient Full Name]
Date of Birth: [Patient DOB]
Date of Surgery: [Surgery Date]

To Whom It May Concern,

I am writing to provide a medical update regarding the visual status of [Patient Name] following their recent surgical procedure.

As of [Date of Evaluation], the patient has been examined and I have determined that they are medically cleared to return to work. Please note the following regarding their vision restrictions:

Clearance Status:

- [ ] Full Clearance: The patient may return to all duties, including driving and operating heavy machinery, without restrictions.
- [ ] Limited Clearance: The patient may return to work with the specific restrictions listed below.

Specific Restrictions (if applicable):

- [ ] No driving or operating motorized equipment.
- [ ] Limit screen time / computer work to [Number] hours per day.
- [ ] Avoid environments with high dust, debris, or chemical fumes.
- [ ] No lifting objects over [Number] pounds to avoid intraocular pressure.
- [ ] Requirement to wear protective eyewear at all times.

Duration: These restrictions are expected to remain in place until [End Date] or until the next follow-up appointment scheduled for [Next Appointment Date].

Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]
[Phone Number / Email]