[Doctor's Name/Clinic Name]
[Address]
[Phone Number]

[Date]

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

RE: RETURN TO WORK MEDICAL CLEARANCE

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

Dear [Manager or HR Representative Name],

I have been treating [Patient Name] for a medical condition. I am writing to certify that I have examined the patient and they are medically cleared to return to work effective [Date].

Please find the status of their return below:

Work Status:
[ ] Full Duties: The patient may return to work with no restrictions.
[ ] Modified Duties: The patient may return to work with the following restrictions:

[List specific restrictions or accommodations needed, e.g., lifting limits, reduced hours, or frequent breaks.]

Duration of Restrictions:
These restrictions are expected to remain in place until [Date] or until further evaluation on [Follow-up Date].

If you have any questions or require additional clarification, please contact my office.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Medical License Number]