[Doctor's Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Employer Name/Company Name]

RE: Medical Clearance for Light Duty Return to Work
Employee Name: [Employee Name]
Date of Birth: [DOB]

To Whom It May Concern,

This letter serves to certify that [Employee Name] has been under my medical care. I have evaluated the patient and determined that they are medically cleared to return to work in a **light duty capacity** effective [Start Date].

Work Restrictions:
The patient is subject to the following limitations until [Date or Next Evaluation]:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Standing/Walking:** No more than [Number] hours per day.
- **Postural:** No [kneeling / squatting / climbing / reaching overhead].
- **Other:** [List any additional restrictions, e.g., desk work only, frequent breaks].

I expect these restrictions to remain in place until the patient's follow-up appointment on [Date]. At that time, their status will be re-evaluated for a potential return to full duty.

If you have any questions regarding these restrictions, please contact my office.

Sincerely,

[Doctor's Signature]

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