

Date: [Date]

To: [Employer Name/Company Name]

From: [Physician Name/Clinic Name]

Subject: Post-Surgical Medical Clearance for [Patient Name]

Dear [Manager or HR Representative Name],

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

Based on my clinical evaluation, [Patient Name] is cleared to return to work on [Return to Work Date] under the following status:

[Select One Option]

- **Full Duty:** The patient may return to work with no physical restrictions.
- **Modified Duty:** The patient may return to work with the following temporary restrictions:
 - [Restriction 1, e.g., No lifting over 10 lbs]
 - [Restriction 2, e.g., Must remain seated for 50% of shift]
 - [Restriction 3, e.g., Limited use of right arm]

These restrictions are expected to remain in place until [Date or Next Appointment Date].

Please contact my office at [Phone Number] if you require further clarification regarding these medical recommendations.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]

[Clinic/Hospital Name]