

Date: [Date]

To: [Employer Name]

Attention: [Manager or HR Name]

Address: [Company Address]

Re: Workers' Compensation Return to Work Clearance

Employee Name: [Employee Name]

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

To Whom It May Concern,

I have examined [Employee Name] on [Date of Evaluation] regarding the injury sustained on the date mentioned above. Based on my clinical evaluation, the employee's status regarding their return to work is as follows:

Status (Select one):

- Full Duty: The employee may return to work with no restrictions effective [Date].
- Modified Duty: The employee may return to work with the restrictions listed below effective [Date].
- Not Cleared: The employee is not yet cleared to return to work.

Work Restrictions (if applicable):

[List specific restrictions: e.g., No lifting over 10 lbs, no repetitive reaching, sedentary work only, etc.]

Duration of Restrictions:

These restrictions are expected to remain in place until [Date] or until the next follow-up appointment on [Date].

Physician's Comments:

[Additional notes or recommendations]

Sincerely,

[Physician Signature]

Physician Name: [Name]

Medical Facility: [Clinic Name]

Phone Number: [Phone Number]