

Date: [Date]

To: [Employer Name/Company Name]

Attention: [Manager or HR Representative Name]

RE: Medical Clearance for Modified Duty

Patient Name: [Employee Full Name]

Date of Birth: [DOB]

Dear [Recipient Name],

I have evaluated [Employee Name] regarding their fitness to return to work following their recent medical leave/injury. I have determined that the patient may return to work in a modified duty capacity effective [**Start Date**].

The following restrictions and limitations apply to the patient's work activities:

- **Physical Restrictions:** [e.g., No lifting over 10 lbs, no prolonged standing]
- **Activity Limitations:** [e.g., No overhead reaching, frequent breaks required]
- **Schedule Modifications:** [e.g., Maximum 4 hours per day, part-time only]

These modifications are expected to remain in place until [**End Date/Follow-up Date**], at which time the patient will be re-evaluated for a full release to duty.

If you are unable to accommodate these specific restrictions, please contact my office to discuss alternative arrangements. If the modified duties are acceptable, the patient is cleared to begin on the date specified above.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Facility Name]

[Phone Number]