

Date: [Insert Date]

To: [Employer Name / Human Resources Department]

Company: [Company Name]

Address: [Company Address]

RE: Medical Clearance for Return to Work

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

To Whom It May Concern,

[Patient Name] has been under my care following a cardiac event/procedure on [Date of Event]. The patient has successfully participated in a supervised Cardiac Rehabilitation program and has undergone a clinical evaluation to assess their functional capacity.

Based on my clinical assessment, I am clearing [Patient Name] to return to work effective [Return Date] under the following status:

Status (Select One):

- Full Duty: The patient may return to all previous job responsibilities without restrictions.
- Modified Duty: The patient may return to work with the specific restrictions listed below.

Specific Restrictions/Accommodations (if applicable):

- Lifting limit: [e.g., No more than 10 lbs]
- Physical activity: [e.g., Avoid strenuous climbing or prolonged aerobic exertion]
- Work hours: [e.g., Maximum 4 hours per day for the first two weeks]
- Other: [Insert additional details]

These restrictions are expected to remain in place until [Date of Re-evaluation].

Please ensure the patient is allowed necessary breaks for hydration and to take prescribed cardiac medications as scheduled.

If you have any questions or require further clarification regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

Signature: _____

Physician Name: [Physician Name, MD/DO]

Title: [e.g., Cardiologist / Medical Director of Cardiac Rehabilitation]

Facility Name: [Hospital/Clinic Name]

Phone: [Phone Number]