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

Date: [Current Date]

To: [Employer Name/Company Name]
Attention: [Manager Name or HR Department]

RE: RETURN TO WORK MEDICAL CLEARANCE

Employee Name: [Employee Full Name]
Date of Injury: [Date of Injury]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

I have evaluated [Employee Name] following their workplace injury. Based on my clinical assessment, the employee is cleared to return to work effective **[Return Date]** under the following status:

[ ] Full Duty: The employee may return to their original position with no physical restrictions.

[ ] Modified Duty: The employee may return to work with the following temporary restrictions until [End Date/Next Evaluation Date]:

- [List restriction, e.g., No lifting over 10 lbs]
- [List restriction, e.g., No prolonged standing]
- [List restriction, e.g., Reduced hours/part-time]

If modified duty is not available, the employee should remain off work until the next scheduled follow-up on [Follow-up Date].

Please contact my office if you have any questions regarding these recommendations.

Sincerely,

_____
[Doctor's Signature]

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