

Date: [Date]

To: [Employer Name/Human Resources Department]

Company: [Company Name]

Address: [Company Address]

RE: Medical Clearance for Return to Work

Employee Name: [Employee Full Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

I am the treating physician for [Employee Name], who has been under my care for an extended medical leave starting from [Start Date of Leave].

I have evaluated the patient and determined that they have recovered sufficiently to return to their professional duties. The patient is medically cleared to return to work on **[Return Date]**.

Status of Clearance:

- Full Duty: The employee may return to work with no physical or schedule restrictions.
- Modified Duty: The employee may return to work with the following restrictions:
[List restrictions or "See attached document"].

These restrictions, if any, are expected to remain in place until [End Date of Restrictions/Follow-up Date].

Please feel free to contact my office at [Phone Number] if you require further clarification regarding this medical clearance.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical Practice/Clinic Name]

[License Number]