

[Medical Provider Letterhead]

Date: [Date]

To: [Agency Name / Chief of Police / HR Department]

Address: [Department Address]

RE: RETURN TO WORK PHYSICAL CLEARANCE

Patient Name: [Officer Full Name]

Date of Birth: [DOB]

Date of Injury/Illness: [Date]

To Whom It May Concern,

I have medically evaluated [Officer Name] on [Date of Examination] regarding their fitness to return to duty following a medical leave of absence.

Based on my clinical findings and the specific physical requirements of law enforcement duty, I certify the following:

Full Duty: The officer is cleared to return to full, unrestricted duty effective [Date]. This includes, but is not limited to, the ability to engage in physical combat, foot pursuits, operation of motor vehicles, and the use of firearms.

Light Duty: The officer is cleared to return to administrative/modified duty only, effective [Date] until [Date]. Restrictions include: [List Restrictions].

Not Cleared: The officer is not yet cleared to return to duty. Next evaluation scheduled for [Date].

If you have any questions regarding this medical clearance, please contact my office at [Phone Number].

Respectfully,

[Physician Signature]

[Physician Name, MD/DO/NP]

[Medical License Number]

[Clinic/Hospital Name]