Date: [Insert Date]

To: [Company Name / Medical Department]
Subject: Medical Clearance for Remote Site Work

Employee Name: [Insert Full Name]
Employee ID/DOB: [Insert ID or Date of Birth]
Project/Site Location: [Insert Site Name]

To whom it may concern,

I have performed a comprehensive medical evaluation of the above-named individual to determine their fitness for duty at a remote work site. My assessment included a review of their medical history, a physical examination, and [Insert any specific tests, e.g., blood work, ECG, or audiometry].

Based on the clinical findings and the nature of the remote environment, I certify that the individual is:

[ ] Fit for Duty: The individual is medically cleared to work in a remote location without restrictions.

[ ] Fit for Duty with Limitations: The individual is cleared to work subject to the following accommodations: [Insert limitations].

[ ] Not Fit for Duty: The individual is not medically cleared for remote site deployment at this time.

This clearance is valid until [Insert Expiration Date], unless a significant change in the individual's health status occurs.

Sincerely,

Practitioner Signature: _____

Practitioner Name: [Insert Name and Title]
License Number: [Insert Number]
Clinic/Facility Name: [Insert Clinic Name]
Contact Phone: [Insert Phone Number]