Date: [Insert Date]

To: [Recipient Name/Employer Name]
Organization: [Company Name]
Address: [Company Address]

Subject: Medical Clearance for Restricted Practice

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

Dear [Recipient Name],

I have medically evaluated [Patient Name] on [Date of Evaluation]. Based on my clinical assessment, the patient is cleared to return to work/practice, subject to the following specific restrictions and limitations:

Authorized Restrictions:

- [Restriction 1: e.g., No lifting over 10 lbs]
- [Restriction 2: e.g., Limited standing to 2 hours per shift]
- [Restriction 3: e.g., No operating heavy machinery]

Duration:
These restrictions are expected to remain in place until [Expected End Date] or until the patient is re-evaluated on [Follow-up Date].

Accommodations Required:
[Describe any specific environmental or equipment needs, or state "None"].

The patient is currently capable of performing all other essential functions of their role that do not conflict with the limitations listed above.

Please contact my office at [Phone Number] if you require further clarification regarding these medical limitations.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]