[Physician Name/Clinic Name]
[Address]
[Phone Number]
[Date]

To: [Employer Name/Human Resources]
[Company Name]
[Address]

RE: Fitness for Duty Evaluation
Patient Name: [Patient Name]
Date of Birth: [DOB]

To Whom It May Concern,

I have completed a psychiatric fitness for duty evaluation for [Patient Name] on [Date of Evaluation]. The purpose of this evaluation was to determine the patient's psychological stability and capacity to perform the essential functions of their position as [Job Title].

Based on my clinical examination, review of medical history, and current mental status, it is my professional opinion that:

**[Select One Option]**

- The patient is **Cleared for Full Duty** without restrictions, effective [Date].
- The patient is **Cleared for Duty with Restrictions**. The following accommodations are required until [End Date]: [List Restrictions].
- The patient is **Not Cleared for Duty** at this time. A follow-up evaluation is scheduled for [Date].

I have determined that the patient does not pose a direct threat to the health or safety of themselves or others in the workplace. This clearance is based on the information available to me at the time of the evaluation.

If you have any questions regarding this evaluation, please contact my office directly.

Sincerely,

[Signature]

[Physician Name, Credentials]
[License Number]