[Physician Name/Clinic Letterhead]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To Whom It May Concern,

RE: Medical Clearance for [Patient Name]
Date of Birth: [DOB]
Date of Surgery: [Surgery Date]

This letter is to confirm that [Patient Name] is under my care following a surgical repair of the [Left/Right] Achilles tendon. I have evaluated the patient on [Date of Last Exam] and found them to be progressing as expected.

Based on their current clinical status, the patient is cleared for the following activities:

- [ ] Return to work (Sedentary/Desk duty)
- [ ] Return to work (Full duty)
- [ ] Return to physical therapy/exercise
- [ ] Weight-bearing as tolerated
- [ ] Driving (Automatic/Manual transmission)

Restrictions and Limitations:
[Insert specific restrictions, e.g., no running, jumping, or lifting over X lbs until specific date]

The patient is currently scheduled to continue follow-up appointments and physical rehabilitation. Please feel free to contact my office if you require further documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]