Date: [Date]

To: [Employer Name / Insurance Carrier]
Attn: [Contact Person/Adjuster]
Re: Workers' Compensation Light Duty Clearance

Patient Name: [Patient Name]
Date of Injury: [Date of Injury]
Claim Number: [Claim Number]

To Whom It May Concern,

I have evaluated [Patient Name] on [Date of Evaluation] regarding the injury sustained on the date referenced above. At this time, I am clearing the patient to return to work in a **Light Duty** capacity effective [Start Date].

The patient is subject to the following physical restrictions:

- **Lifting/Carrying:** No more than [Number] lbs.
- **Pushing/Pulling:** No more than [Number] lbs. of force.
- **Postural Limits:** No [stooping/kneeling/crouching/climbing].
- **Reaching:** [No overhead reaching / Limited reaching with Left/Right arm].
- **Repetitive Motion:** [Limit use of hands/wrists/fingers to X hours per day].
- **Ambulatory:** [Sitting only / Limited standing / Use of assistive device].

Other Specific Instructions:
[Insert any additional details or "None"]

These restrictions are expected to remain in place until [Expected End Date] or until the patient's next follow-up appointment on [Follow-up Date]. Please ensure that the assigned work duties strictly adhere to these medical limitations to prevent further injury.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Medical Facility Name]
[Phone Number]