Date: [Date]

To: [Employer Name / Human Resources Department]
From: [Physician Name / Medical Facility]
Subject: Restricted Duty Medical Clearance

Patient Name: [Patient Name]
Date of Birth: [Patient Date of Birth]
Date of Examination: [Date of Exam]

To Whom It May Concern,

The above-named patient has been under my medical care. Based on my recent evaluation, I have determined that the patient may return to work in a restricted duty capacity beginning on **[Start Date]**.

The patient is subject to the following work restrictions:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Postural Limits:** [e.g., No bending, kneeling, or overhead reaching]
- **Mobility:** [e.g., No prolonged standing; must sit for 10 minutes every hour]
- **Environmental:** [e.g., Avoid heavy machinery or vibrating tools]
- **Other:** [List any additional specific restrictions]

These restrictions are expected to remain in place until **[End Date or Follow-up Date]**. The patient will be re-evaluated at that time to determine if restrictions can be lifted or modified.

If you are unable to accommodate these temporary restrictions, please contact the patient or my office directly.

Sincerely,

[Physician Signature]

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