Date: [Date]

To: [Employer Name/Company Name]
Attention: [Manager or HR Department]
Address: [Company Address]

Subject: Work Capacity Evaluation Clearance

To whom it may concern,

This letter serves to confirm that I have completed a Work Capacity Evaluation for **[Employee Name]**, born on **[Date of Birth]**, regarding their fitness to perform occupational duties.

Based on the clinical examination and functional assessment conducted on **[Date of Evaluation]**, the following determination has been made:

- **Clearance Status:** [Full Clearance / Modified Duty / Not Cleared]
- **Effective Date:** [Start Date]

Functional Limitations and Restrictions (if any):

[List specific restrictions such as lifting limits, sitting/standing durations, or "None" if fully cleared.]

Follow-up Requirements:

[List any necessary follow-up appointments or the date for a re-evaluation, if applicable.]

In my professional opinion, the employee is capable of performing the tasks outlined in their job description within the parameters mentioned above without posing a significant risk to themselves or others.

Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

[Signature]
[Practitioner Name, Title]
[Medical Facility/Clinic Name]
[License Number]