[Doctor's Name/Clinic Name]
[Doctor's Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

To: [Employer or School Name]

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

To Whom It May Concern,

I have medically evaluated [Patient Name] following their recent injury. Based on the physical examination and review of their progress, I am providing the following clearance regarding their return to activities:

Status (Select One):

- Full Clearance: The patient may return to all duties/activities without restrictions effective [Date].
- Modified Duty: The patient may return to work/school with the following restrictions effective [Date] until [End Date/Re-evaluation Date].

Specific Restrictions (if applicable):
[List restrictions such as lifting limits, standing limits, or modified hours]

Follow-up:
[The patient is scheduled for a follow-up on [Date] / No further follow-up is required at this time].

Please contact my office if you require any further clarification.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical License Number]