Date: [Insert Date]

To: [Claims Adjuster Name / Case Manager]
Company: [Insurance Carrier Name]
Claim Number: [Insert Claim Number]

RE: Fit for Duty Certification
Employee Name: [Insert Employee Name]
Date of Injury: [Insert Date of Injury]

To Whom It May Concern,

I have performed a formal medical evaluation of [Employee Name] on [Date of Examination] to determine their physical readiness to return to work following the work-related injury sustained on [Date of Injury].

Based on my clinical findings and the requirements of the patient's job description, I have determined the following status:

[ ] Full Duty: The employee is released to return to their regular job duties without any physical restrictions, effective [Date].

[ ] Modified Duty: The employee is released to return to work with the following restrictions, effective [Date] through [End Date]:

- Lifting/Carrying: Not to exceed [Number] lbs.
- Pushing/Pulling: Not to exceed [Number] lbs.
- Postural: [e.g., No prolonged standing, kneeling, or overhead reaching]
- Work Schedule: [e.g., Maximum 4 hours per day]

[ ] Not Fit for Duty: The employee remains unable to return to work in any capacity at this time. A follow-up evaluation is scheduled for [Date].

I will continue to monitor the patient's progress. Please contact my office at [Phone Number] if you require further clarification regarding these clinical recommendations.

Sincerely,

[Physician Signature]
[Physician Name, Degree]
[Medical Facility Name]
[License Number]