[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To Whom It May Concern,

RE: RETURN TO WORK/SCHOOL CLEARANCE

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Date of Examination: [Date]

This letter is to certify that [Patient Name] has been under my care for a medical condition. Following a clinical evaluation, I have determined that the patient is now medically cleared to return to their regular duties/classes.

Clearance Status (Check One):

[ ] Full Clearance: The patient may return to full duty without any restrictions effective [Date].

[ ] Restricted Clearance: The patient may return to duty effective [Date], with the following limitations:

- [Restriction 1]
- [Restriction 2]

These restrictions are expected to remain in place until [Date/Follow-up Appointment].

Should you require any further information or clarification, please do not hesitate to contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]