Date: [Date]

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

Subject: Modified Duty Medical Clearance for [Employee Name]

Dear [Recipient Name],

This letter serves to certify that [Employee Name] has been medically evaluated and is cleared to return to work in a modified or light-duty capacity effective [Start Date].

Based on the clinical assessment, the following restrictions apply to the employee's duties:

- **Lifting/Carrying:** May not lift more than [Number] pounds.
- **Physical Movements:** Restrict [bending, stooping, reaching, or climbing].
- **Mobility:** No prolonged [standing/walking] for more than [Number] minutes at a time.
- **Equipment:** Do not operate [Specific Machinery or Vehicles].
- **Other:** [Specify any other limitations].

The employee is expected to work a modified schedule of [Number] hours per day, [Number] days per week. These restrictions are expected to remain in effect until [End Date or Re-evaluation Date].

A follow-up appointment is scheduled for [Date] to reassess the employee's status and determine if further modifications or a full release to duty are appropriate.

Please contact my office at [Phone Number] if you require further clarification regarding these medical limitations.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Medical Facility Name]
[License Number]