RETURN TO WORK / FITNESS FOR DUTY CERTIFICATION

Date: [Date]

To: [Employer Name/Human Resources Department]
Company: [Company Name]
Address: [Company Address]

Employee Name: [Employee Full Name]
Date of Birth: [Employee DOB]

To Whom It May Concern,

I have examined the above-named employee and evaluated their medical condition in relation to their job requirements.

Medical Status (Check one):

[ ] The employee is cleared to return to full duty without restrictions, effective: **[Date]**

[ ] The employee is cleared to return to work with the following temporary restrictions, effective: **[Date]**

Specific Restrictions/Accommodations (if applicable):
[List restrictions such as lifting limits, standing duration, reduced hours, etc.]

These restrictions are expected to remain in place until: **[Date]**

[ ] The employee is NOT cleared to return to work at this time. A follow-up evaluation is scheduled for: **[Date]**

Health Care Provider Information:

Provider Name: [Name of Physician/Provider]
Practice Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]
Address: [Provider Address]

_____
Signature of Health Care Provider

_____

Date Signed