

[Physician Name/Clinic Name]  
[Address Line 1]  
[City, State, Zip Code]  
[Phone Number]  
[Email]

Date: [Insert Date]

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

**RE: Psychiatric Fitness for Duty and Return to Work Clearance**

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

To Whom It May Concern,

I am the treating [Psychiatrist/Licensed Mental Health Professional] for [Employee Name]. The above-named employee has been under my care since [Start Date] and has undergone a clinical evaluation to determine their fitness for duty.

Based on my clinical findings and the patient's current mental status, I have determined that [Employee Name] is psychologically fit to return to their position and perform the essential functions of their job.

**Return to Work Status:**

[ ] The employee may return to full duty without restrictions effective: [Date].

[ ] The employee may return to work with the following temporary accommodations/restrictions effective [Date] until [End Date]:

[Insert specific restrictions or "None"].

I will continue to monitor the patient's progress through scheduled follow-up appointments. Should you have any questions regarding this clearance, please contact my office directly.

Sincerely,

[Signature]

[Physician Name, Credentials]  
[License Number]  
[Clinic Stamp/Seal]