[Doctor's Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Employer Name/HR Department]
[Company Name]
[Address]

RE: RETURN TO WORK FITNESS CERTIFICATION

Patient Name: [Patient Name]
Date of Birth: [DOB]
Surgery Date: [Date of Procedure]

To Whom It May Concern,

I am writing to certify that [Patient Name] has been under my care following a surgical procedure. I have evaluated the patient and determined their fitness to return to work.

The patient is cleared to return to work effective: **[Return Date]**

Status (Select one):

[ ] The patient may return to full duty without restrictions.

[ ] The patient may return to work with the following temporary restrictions until [End Date]:
- [e.g., No lifting over 10 lbs]
- [e.g., Must remain seated for 50% of shift]
- [e.g., Limited use of right/left arm]

The patient is scheduled for a follow-up evaluation on [Follow-up Date].

Should you require any further clarification regarding these medical instructions, please contact my office.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Medical License Number]