

Date: [Date]

To: [Employer Name / Supervisor Name]

Company: [Company Name]

Address: [Company Address]

RE: Partial Restriction Return to Work Certification

Employee Name: [Employee Name]

Employee ID: [Employee ID/Optional]

To Whom It May Concern,

This letter serves to certify that [Employee Name] has been under my medical care and is cleared to return to work with specific restrictions effective **[Date]**.

Based on my medical evaluation, the employee is capable of performing light-duty or modified-duty tasks within the following parameters:

1. Physical Restrictions:

- Lifting/Carrying: No more than [Number] lbs.
- Standing/Walking: Maximum of [Number] hours per shift.
- Postural: [e.g., No bending, squatting, or overhead reaching].
- Other: [Specify].

2. Schedule Restrictions:

- Maximum hours per day: [Number].
- Maximum days per week: [Number].
- Mandatory breaks: [e.g., 15 minutes of rest every 2 hours].

3. Duration:

These restrictions are expected to remain in place until **[Date]**, at which time the employee will be re-evaluated for full duty or further modifications.

Please confirm if your organization can accommodate these temporary restrictions. If these accommodations cannot be met, please notify the employee immediately.

Sincerely,

[Physician Signature]

Physician Name: [Print Name]

Medical Facility: [Clinic/Hospital Name]

Phone Number: [Phone Number]

Medical License #: [Number]