

[Date]

[Employer Name]

[Company Name]

[Company Address]

[City, State, Zip Code]

RE: RETURN TO WORK CLEARANCE FOR [Employee Full Name]

To Whom It May Concern,

This letter is to certify that I have evaluated [Employee Full Name] on [Date of Examination].

Based on my medical evaluation, the patient is cleared to return to work in a full, unrestricted capacity effective [Date of Return].

The patient is fit to perform all essential job functions and regular duties associated with their position. There are no medical restrictions, limitations, or accommodations required at this time.

Please contact my office at [Phone Number] if you require any further information.

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[Medical Practice Name]

[License Number]