

Date: [Date]

To: [Employer Name/Human Resources]

Company: [Company Name]

RE: Communicable Disease Clearance for Return to Work

Employee Name: [Employee Full Name]

Date of Birth: [Employee DOB]

To Whom It May Concern,

I have evaluated the above-named employee following a diagnosis or exposure to a communicable disease. Based on my clinical examination and/or laboratory results, I certify that the employee has met the necessary health criteria for clearance.

The employee is no longer considered contagious and is medically cleared to return to their regular work duties effective **[Date of Return]**.

Work Status (Check one):

- Full duties, no restrictions.
- Modified duties (see attached notes).

If you have any questions or require further verification, please contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Facility/Clinic Name]

[Phone Number]