

Date: [Insert Date]

To: [Employer Name/HR Department]

Company: [Company Name]

Address: [Company Address]

Subject: Occupational Health Fitness for Duty Certification

Dear [Contact Person Name],

I have completed an occupational health evaluation for **[Employee Name]**, DOB: **[Employee Date of Birth]**, to determine their fitness to return to duty following their recent medical leave.

Based on my clinical assessment and review of the job requirements, I have determined the following:

Status:

- **Fit for Full Duty:** The employee may return to their regular position without restrictions effective [Date].
- **Fit for Modified Duty:** The employee may return to work with the restrictions listed below effective [Date] until [End Date/Review Date].
- **Not Fit for Duty:** The employee is currently unable to perform the essential functions of their role.

Work Restrictions (if applicable):

[Insert specific restrictions regarding lifting, standing, hours worked, etc.]

Follow-Up:

[Insert follow-up appointment date or "No further follow-up required".]

If you require further clarification regarding these recommendations, please contact my office.

Sincerely,

[Signature]

[Provider Name, Title]

[Clinic/Medical Facility Name]

[Phone Number]