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

[Date]

[Employer Name]
[Company Name]
[Company Address]

RE: Return to Work Medical Clearance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]

To Whom It May Concern,

This letter is to confirm that [Patient Full Name] has been under my care for pregnancy and postpartum recovery. She is medically cleared to return to her employment duties effective [Date of Return].

Regarding her return to work status (check one):

- [ ] She may return to full duty without any physical restrictions.
- [ ] She may return to work with the following temporary modifications: [List restrictions, e.g., lifting limits, frequent breaks, or reduced hours] until [End Date].

Additionally, please provide the necessary accommodations for lactation as required by law, including access to a private space and reasonable break times.

If you have any questions regarding this clearance, please contact my office.

Sincerely,

[Doctor's Signature]

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