

Date: [Date]

To: [Employer Name/Human Resources Department]

Company: [Company Name]

Address: [Company Address]

RE: Medical Certification of Work Restrictions

Employee Name: [Employee Name]

Date of Birth: [DOB]

To Whom It May Concern,

I am the treating healthcare provider for [Employee Name]. This letter serves to certify that the patient has a chronic serious health condition that necessitates specific workplace restrictions and/or accommodations to manage their health effectively while maintaining employment.

Duration of Condition:

The condition is chronic in nature. The anticipated duration of the need for these restrictions is from [Start Date] to [End Date/Permanent].

Required Work Restrictions:

Based on the patient's current medical status, the following restrictions are required:

- [Restriction 1: e.g., No lifting over 10 lbs]
- [Restriction 2: e.g., Ability to sit/stand as needed]
- [Restriction 3: e.g., Maximum 40 hours per week with no overtime]
- [Restriction 4: e.g., Need for intermittent leave for flare-ups or treatments]

Frequency of Potential Intermittent Absence:

Due to the nature of this chronic condition, the patient may experience episodes of incapacity. I estimate the frequency of these episodes to be [Number] times per [Week/Month], lasting [Duration] per episode.

These restrictions are medically necessary to prevent the aggravation of the patient's condition. Please let us know if further clarification is required regarding these functional limitations.

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[Medical License Number]

[Clinic/Facility Name]

[Phone Number]