Date: [Insert Date]

To: [Recipient Name/Organization]
Fax/Address: [Insert Fax Number or Address]

RE: Orthopedic Disability Statement

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Date of Surgery: [MM/DD/YYYY]
Procedure: [Insert Type of Orthopedic Surgery]

To Whom It May Concern,

This letter serves to certify that the above-named patient is currently under my professional care following a major orthopedic surgical procedure. Due to the nature of this surgery and the requirements for proper healing, the patient is considered temporarily disabled and unable to perform their regular work or academic duties.

Disability Period:
The patient is completely excused from work/school starting [Start Date] through [Estimated End Date].

Physical Restrictions:
During this recovery period, the patient is subject to the following limitations:

- No lifting, pushing, or pulling greater than [Number] pounds.
- No prolonged standing or walking (more than [Number] minutes).
- Restricted use of the [Left/Right] [Body Part, e.g., Knee/Shoulder].
- Patient must keep the operative limb elevated.
- Patient is currently using [Crutches/Walker/Sling/Brace] for mobilization.

Return to Work Plan:
The patient is scheduled for a follow-up evaluation on [Follow-up Date]. At that time, their physical status will be reassessed to determine if they can return to "Light Duty" or full unrestricted activity.

If you require further clinical documentation or have questions regarding these restrictions, please contact my office directly.

Sincerely,

[Physician Signature]
[Physician Name, M.D./D.O.]
[Medical Practice Name]
[Phone Number]