[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

To Whom It May Concern,

I am writing to provide medical clearance for my patient, **[Employee Name]**, who has been under my care since [Date].

After a medical evaluation, I have determined that [Employee Name] is fit to return to work on **[Return Date]**.

Please follow the checked status below regarding their work duties:

[ ] **Full Duty:** The employee may return to work without any restrictions or limitations.

[ ] **Modified Duty:** The employee may return to work with the following restrictions until [End Date]:
[List specific restrictions, e.g., no lifting over 10 lbs, frequent breaks, etc.]

If you have any questions regarding this clearance, please contact my office at [Phone Number].

Sincerely,

[Doctor's Signature]

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