[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

RE: [Patient Name]
Date of Birth: [DOB]
Date of Surgery: [Surgery Date]

To Whom It May Concern:

This letter serves to confirm that [Patient Name] is currently under my care for orthopedic surgical treatment involving the [Body Part/Procedure].

Due to the nature of this procedure and the requirements of the recovery process, the patient is currently considered disabled and is unable to return to work at this time.

Estimated Duration of Disability: [Number of weeks/months]
Expected Return to Work Date: [Date] (Pending clinical evaluation)

Upon returning to work, the patient will likely require the following restrictions:

- No lifting more than [Number] pounds.
- No repetitive bending, twisting, or reaching.
- Ability to change positions (sitting/standing) as needed for pain management.
- Limited use of the affected extremity.

The patient will be re-evaluated on [Follow-up Date], at which time their status may be updated. Please contact our office if you require any further documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]