[Date]

To: [Employer Name / Human Resources]
From: [Physician Name, MD/DO]
Facility: [Clinic/Medical Office Name]
Phone: [Phone Number]

RE: Return to Work Authorization for [Patient Full Name]

To Whom It May Concern,

I have examined [Patient Name] on [Date of Examination]. The patient may return to work in a light duty capacity effective [Start Date] through [End Date/Date of Re-evaluation].

The patient is subject to the following physical restrictions:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Postural:** No frequent bending, twisting, or kneeling.
- **Reaching:** No overhead reaching or reaching away from body with [Left/Right/Both] arm.
- **Mobility:** Limit [Standing/Walking] to [Number] minutes per hour. Sedentary work preferred.
- **Scheduling:** Limit work day to [Number] hours per day.

Specific Instructions/Notes:
[Insert any additional medical requirements here]

I expect these restrictions to be temporary. I will re-evaluate the patient's status on [Date of Next Appointment] to determine if restrictions can be lifted or modified.

Please contact my office if you have any questions regarding these limitations.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[License Number]