

Date: [Date]

To: [Employer Name/Company Name]

From: [Physician Name/Clinic Name]

Subject: Return to Work with Restrictions for [Patient Name]

To Whom It May Concern,

This letter serves to confirm that [Patient Name] underwent a surgical procedure on [Date of Surgery]. The patient is cleared to return to work on [Return Date], subject to the following light duty restrictions:

Physical Restrictions:

- **Lifting/Carrying:** No more than [Weight, e.g., 5 or 10] pounds.
- **Movement:** No bending, twisting, or reaching above shoulder height.
- **Mobility:** Patient must be allowed to [sit/stand] for [Number] minutes every hour.
- **Operation:** No operating heavy machinery or driving company vehicles.

Schedule Restrictions:

- Patient is restricted to [Number] hours of work per day.

These restrictions are currently in effect until [End Date or Next Evaluation Date]. We will re-evaluate the patient's progress at their next follow-up appointment.

If you have any questions regarding these medical limitations, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Medical Facility Name]