Date: [Date]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Injury/Surgery: [Date]

To Whom It May Concern,

[Patient Name] has been under my orthopedic care for [Condition/Injury]. Based on my most recent evaluation, the patient may return to work in a **Light Duty** capacity effective [Start Date].

The following physical restrictions apply through [End Date or Next Evaluation Date]:

- **Lifting/Carrying:** No more than [Number] pounds.
- **Pushing/Pulling:** No more than [Number] pounds of force.
- **Postural:** No frequent [bending / stooping / squatting / climbing].
- **Reaching:** [No overhead reaching / No reaching with left arm / No reaching with right arm].
- **Movement:** Patient must be allowed to [alternate sitting and standing every hour / use a supportive brace].
- **Repetition:** No repetitive [grasping / fine manipulation / typing] with the affected limb.

The patient is scheduled for a follow-up appointment on [Date]. At that time, their progress will be reviewed and restrictions will be updated as necessary.

If these accommodations cannot be met, the patient is to remain off work until the next evaluation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic Name]
[Phone Number]