Date: [Date]

To: [Employer Name/Company Name]
Attn: [Manager or HR Department Name]

Subject: Medical Clearance and Return to Work with Restrictions

Patient Name: [Employee Name]
Date of Birth: [DOB]

To Whom It May Concern,

I have evaluated [Employee Name] on [Date of Evaluation]. Based on my clinical assessment, the employee is cleared to return to work effective [Start Date] with the following light duty restrictions:

Duration of Restrictions:
These restrictions are expected to remain in place until [End Date or Next Evaluation Date].

Specific Work Restrictions:

- **Lifting:** No lifting/carrying over [Number] pounds.
- **Postures:** No prolonged [standing/sitting/bending/crawling].
- **Mobility:** No climbing ladders or working at heights.
- **Repetitive Motion:** Limited use of [left/right] hand or arm.
- **Environment:** [e.g., Avoid loud noises, extreme temperatures, or driving].
- **Schedule:** Restricted to [Number] hours per shift.

Additional Comments:
[Insert any other specific medical instructions here]

Please contact my office at [Phone Number] if you require further clarification regarding these limitations.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical Facility Name]
[Address]