PHYSICIAN'S CERTIFICATION OF RETURN TO WORK

Date: [Date]

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

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

To whom it may concern,

I have evaluated [Patient Name] on [Date of Evaluation]. It is my medical opinion that the patient may return to work effective [Date of Return], subject to the following light duty restrictions:

Physical Restrictions:

- Lifting/Carrying: No more than [Number] lbs.
- Pushing/Pulling: No more than [Number] lbs. of force.
- Bending/Stooping/Twisting: [None / Limited / Not permitted]
- Standing/Walking: No more than [Number] hours per day.
- Sitting: No more than [Number] hours per day.
- Reaching: [No reaching above shoulder height / No reaching with (Left/Right) arm]

Work Schedule Restrictions:

- Maximum hours per day: [Number]
- Maximum days per week: [Number]
- Required breaks: [Frequency and duration of breaks]

Other Specific Restrictions:
[Insert any additional details, such as use of tools, machinery, or environment constraints]

These restrictions are expected to remain in effect until [Date] or until the patient's next follow-up appointment on [Date]. At that time, the patient's progress will be re-evaluated to determine if restrictions can be modified or lifted.

If you are unable to accommodate these temporary light duty restrictions, please notify the patient immediately.

Sincerely,

[Physician Signature]
[Physician Name, Printed]

[Medical Facility Name]
[Phone Number]