

Date: [Date]

To: [Employer Name/Company Name]

Attention: [Manager or HR Department Name]

Address: [Company Address]

Subject: Fitness for Duty Medical Certification

Patient Name: [Employee Full Name]

Date of Birth: [DOB]

Date of Examination: [Date]

To Whom It May Concern,

I have performed a clinical evaluation of [Employee Name] to determine their physical and mental fitness to perform the essential functions of their job as a [Job Title].

Based on my examination and the job description provided, I certify the following:

The employee is fit to return to full duty without any restrictions, effective [Date].

The employee is fit to return to duty with the following temporary restrictions from [Start Date] to [End Date]:

- [List Specific Restrictions, e.g., No lifting over 10 lbs]

- [List Specific Restrictions]

The employee is currently not fit to return to duty. A re-evaluation is scheduled for [Date].

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

Sincerely,

[Healthcare Provider Signature]

[Printed Name and Title]

[Medical Facility/Clinic Name]

[License Number]