

**Date:** [Insert Date]

**To:** [Employer Name/HR Department]

**Company:** [Company Name]

**Address:** [Company Address]

**Subject: Restricted Duty Medical Clearance Certification**

**Patient Name:** [Employee Name]

**Date of Birth:** [Employee DOB]

**Date of Examination:** [Date]

To Whom It May Concern,

I have medically evaluated the above-named patient. It has been determined that the patient may return to work with specific restrictions effective [**Start Date**] through [**Estimated End Date**].

The following physical and/or functional restrictions apply:

- **Lifting/Carrying:** No more than [Number] lbs.
- **Postural:** No [bending / stooping / squatting / climbing / reaching above shoulder].
- **Mobility:** [Limit walking to X hours / No prolonged standing / Sedentary work only].
- **Manual Dexterity:** [No repetitive typing / No grasping with right or left hand].
- **Schedule:** [Limit to X hours per day / Frequent breaks required].

**Other Specific Instructions:**

[Insert any additional medical notes or specific task limitations here]

The patient is scheduled for a follow-up evaluation on [**Follow-up Date**], at which time their work status will be reviewed and updated.

If you have any questions regarding these medical restrictions, please contact my office.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[Clinic/Medical Facility Name]

[Phone Number]