

Date: [Date]

To: [Employer Name/Company Name]

Attention: [HR Department/Supervisor Name]

Subject: Medical Clearance for Fitness for Duty

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter is to certify that [Patient Name] has been under my surgical care for [Type of Procedure/Surgery] performed on [Date of Surgery].

Following a post-operative evaluation on [Date of Evaluation], I have determined that the patient is medically cleared to return to work effective [**Return to Work Date**].

Status of Release (Check one):

Full Duty: The patient may return to all previous job duties and physical requirements without restrictions.

Restricted Duty: The patient may return to work with the following temporary limitations until [Date of Next Review]:

- Lifting restrictions: [e.g., No more than 10 lbs]
- Physical activity: [e.g., No prolonged standing/climbing]
- Other: [Specify any other restrictions]

I will re-evaluate the patient's status on [Follow-up Date] to determine if restrictions can be lifted.

If you require any further information or clarification regarding these instructions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical Practice/Clinic Name]

[License Number]