[Date]

[Doctor Name]
[Clinic/Medical Facility Name]
[Address]
[City, State, Zip Code]

RE: Fitness for Duty Evaluation

Patient Name: [Employee Name]
Date of Birth: [DOB]
Date of Injury: [DOI]
Claim Number: [Claim #]

Dear Dr. [Doctor Last Name],

Our employee, [Employee Name], is currently seeking medical clearance to return to work following a workers' compensation injury. To assist us in determining their ability to perform their job safely, we request a formal Fitness for Duty Evaluation.

Attached to this letter is a copy of the employee's formal Job Description, outlining their essential functions and physical requirements. Please evaluate the patient and provide answers to the following:

- Is the employee physically and mentally capable of performing the essential functions of their job as described?
- Can the employee return to full duty without restrictions? If so, please provide the effective date.
- If the employee cannot return to full duty, please list specific permanent or temporary work restrictions (e.g., lifting limits, standing duration, reaching, etc.).
- Is the employee currently taking any medications that may impair their ability to operate machinery or perform their duties safely?

Please return the completed evaluation or a Work Status Note to our office via fax at [Fax Number] or email at [Email Address].

Thank you for your time and professional assessment.

Sincerely,

[Your Name]
[Your Title]
[Company Name]
[Phone Number]