

Date: [Date]

To: [Employer Name/HR Department]

Company: [Company Name]

Address: [Company Address]

Subject: Medical Certification for Light Duty Accommodation

To Whom It May Concern,

I am the treating healthcare provider for **[Employee Name]**, whose date of birth is **[Date of Birth]**. This letter serves as medical certification regarding the employee's current physical limitations and the necessity for light duty accommodation.

Due to a diagnosed medical condition, the employee is cleared to return to work, provided the following restrictions are observed:

- **Lifting/Carrying:** May not lift or carry more than [Number] pounds.
- **Postural Restrictions:** No [bending, stooping, kneeling, or overhead reaching].
- **Mobility:** Limited to [standing/walking] for no more than [Number] hours per day.
- **Repetitive Motion:** Restrict use of [left/right] hand or arm for repetitive tasks.
- **Other:** [List any specific environmental or additional restrictions].

These restrictions are effective as of **[Start Date]** and are expected to remain in place until approximately **[End Date or Follow-up Date]**.

In my professional opinion, these accommodations are necessary to allow the employee to perform essential job functions without risking further injury or aggravating their condition. I will re-evaluate the employee's status on **[Next Appointment Date]**.

If you have any questions or require further clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Degree]

[Medical Facility Name]

[Medical License Number]