Date: [Insert Date]

To: [Employer Name/HR Department]
Company: [Company Name]
Address: [Company Address]

Subject: Annual Occupational Fitness for Duty Clearance

Employee Name: [Employee Full Name]
Employee ID: [Employee ID Number]
Date of Birth: [Employee DOB]
Job Title: [Job Title/Position]

To whom it may concern,

I have completed the annual occupational health medical evaluation for the above-named employee on [Date of Examination]. The evaluation was conducted to determine the employee's physical and mental fitness to perform the essential functions of their designated job role.

Based on the medical history provided, physical examination findings, and relevant diagnostic tests, my clinical determination is as follows:

[ ] Fit for Duty: The employee is cleared to perform all essential job functions without restrictions.

[ ] Fit for Duty with Restrictions: The employee is cleared to work with the following temporary/permanent limitations:
[Insert specific restrictions or accommodations here]

[ ] Temporarily Unfit for Duty: The employee is not cleared to perform their duties at this time. A follow-up evaluation is required on [Date].

This clearance is valid until [Expiration Date, typically one year from exam].

Sincerely,

[Physician Signature]

Practitioner Name: [Print Name]
Title: [Medical Title/MD/DO]
License Number: [Medical License #]
Clinic/Facility Name: [Clinic Name]
Contact Number: [Phone Number]