[Healthcare Provider Name/Clinic Name]
[Address Line 1]
[Address Line 2]
[Phone Number]

Date: [Date]

To: [Employer Name/Company Name]
Attn: [Supervisor or HR Department]

RE: RETURN TO WORK CLEARANCE

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

I have evaluated [Patient Full Name] regarding their medical leave that began on [Start Date of Absence].

Based on my medical assessment, the patient is cleared to return to work on **[Return Date]** under the following conditions:

Status (Check one):

[ ] Full Duty: The patient may return to work without any restrictions.
[ ] Modified Duty: The patient may return to work with the following restrictions:

Restrictions (if applicable):
[Insert specific restrictions such as lifting limits, sitting/standing durations, or reduced hours]

These restrictions are expected to remain in effect until [End Date for Restrictions] or until the patient is re-evaluated.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]