[Physician Name/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

RE: Post-Surgical Disability Certification

Patient Name: [Patient Name]
Date of Birth: [DOB]
Surgery Date: [Date of Procedure]

To Whom It May Concern,

This letter is to certify that [Patient Name] is currently under my care following a [Type of Surgery/Procedure]. Due to the nature of this surgery and the requirements for a safe recovery, the patient is currently unable to perform their regular work duties.

Disability Period:
The patient is restricted from all work activities beginning [Start Date] and is expected to remain unable to work until [Estimated End Date].

Specific Restrictions:
During the recovery period, the patient must adhere to the following limitations:

- [Limit on lifting, e.g., No lifting over 5 lbs]
- [Mobility limits, e.g., No prolonged standing or walking]
- [Medication effects, e.g., Use of sedative pain medication]
- [Other specific restrictions]

I will re-evaluate the patient's status on [Follow-up Appointment Date] to determine if they can return to work, with or without modifications. Updated documentation will be provided at that time if an extension or light-duty transition is necessary.

Should you require any further information, please contact my office.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical License Number]