Date: [Insert Date]

To: [Recipient Name/Employer/Physician Name]
From: [Physical Therapist Name], PT, DPT
Subject: Functional Capacity Clearance for [Patient Full Name]

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

To Whom It May Concern,

[Patient Name] has been under my care for physical therapy following [Injury/Condition/Surgery]. A comprehensive Functional Capacity Evaluation (FCE) was performed on [Date] to determine the patient's current physical capabilities and readiness for activity.

Based on the clinical findings, the patient is cleared for the following status:

[ ] Full Clearance: The patient may return to full, unrestricted duties and activities. They have demonstrated the strength, mobility, and endurance required for their specific functional goals.

[ ] Modified Clearance: The patient may return to activity with the following specific restrictions:

- **Lifting/Carrying:** Limited to [Number] lbs.
- **Postural:** Limited [Bending/Squatting/Reaching/Climbing].
- **Duration:** Limited to [Number] hours per day.
- **Other:** [List specific restrictions].

Effective Date: [Start Date for Clearance]
Follow-up: The patient is scheduled for a follow-up evaluation on [Date].

If you require further clarification regarding these functional measurements or the clinical reasoning behind this clearance, please contact our office at [Phone Number].

Sincerely,

[Signature]

[Physical Therapist Name], PT, DPT
[License Number]
[Clinic Name]