Date: [Insert Date]

To: [Vocational Rehabilitation Counselor Name]
Organization: [Agency/Organization Name]
Address: [Street Address, City, State, Zip Code]

Re: Post-Surgical Vocational Rehabilitation Clearance

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

To Whom It May Concern,

I am the attending [Surgeon Title/Specialty] for [Patient Name]. This letter serves to provide medical clearance for the aforementioned patient to participate in vocational rehabilitation services following their recent surgical procedure.

As of [Date of Evaluation], the patient is medically stable and has reached a stage in their recovery where they may begin vocational activities under the following parameters:

1. Clearance Status:
[ ] Full clearance with no restrictions.
[ ] Modified clearance with restrictions (see below).

2. Functional Limitations and Restrictions:
[Insert specific restrictions regarding lifting, standing, sitting, repetitive motions, or environmental exposures, e.g., "No lifting over 10 lbs for 4 weeks"].

3. Recommended Accommodations:
[Insert necessary workplace or training adjustments, e.g., "Requires ergonomic seating" or "Frequent rest breaks"].

4. Duration of Restrictions:
These restrictions are expected to remain in place until [Date or Next Follow-up Appointment].

In my medical opinion, the patient is capable of participating in [Job Training / Job Placement / Educational Programs] provided that the stated restrictions are observed. We will continue to monitor the patient's progress and will update their status as necessary.

Should you require further medical documentation or clarification, please contact my office at [Phone Number].

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name, MD/DO]
[Medical Practice Name]
[License Number]