

Date: [Insert Date]

Re: Occupational Therapy Job Readiness Clearance

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

This letter serves to certify that [Patient Name] has been under my care for Occupational Therapy services from [Start Date] to [End Date]. The primary focus of treatment was to address functional limitations impacting the patient's ability to perform work-related tasks.

As of [Date of Evaluation], I have completed a formal assessment of the patient's physical, cognitive, and sensory-motor capabilities. Based on the objective findings and the patient's progress toward therapeutic goals, it is my professional opinion that [Patient Name] is clinically cleared to return to work.

Clearance Status:

Cleared for Full Duty without restrictions.

Cleared for Modified Duty with the following restrictions/accommodations:

- [Insert Restriction 1, e.g., Lifting limit of 20 lbs]
- [Insert Restriction 2, e.g., Frequent postural breaks required]
- [Insert Restriction 3, e.g., Ergonomic equipment needed]

These recommendations are effective through [End Date or "Until Further Notice"].

If you require any further documentation or clarification regarding the patient's functional status, please contact my office at [Phone Number].

Sincerely,

[Signature]

[Printed Name], OTR/L

[Facility Name]

[License Number]