Date: [Date]

To: [Employer Name/Human Resources Department]
Company: [Company Name]
Address: [Company Address]

Subject: Permanent Medical Restrictions and Clearance for [Employee Name]

To Whom It May Concern,

I am writing to provide a formal medical clearance update for [Employee Full Name], born on [Date of Birth]. I have been treating the patient for [Medical Condition/Injury].

Based on my clinical evaluation and the patient's progress, it has been determined that [Employee Name] has reached Maximum Medical Improvement (MMI). While they are cleared to return to work, they are subject to the following **permanent** physical restrictions:

- **Lifting/Carrying:** May not lift or carry more than [Number] pounds.
- **Postural:** No [crouching/kneeling/crawling/climbing].
- **Repetition:** Limited use of [Right/Left] hand for repetitive tasks.
- **Mobility:** Must be allowed to [sit/stand] for [Number] minutes every hour.
- **Other:** [List any additional permanent restrictions].

These restrictions are considered permanent and are necessary to prevent further injury or aggravation of the patient's condition. [Employee Name] is medically cleared to perform all other essential job functions that do not conflict with the limitations listed above.

If you have any questions regarding these restrictions or require further clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, M.D./D.O.]
[Medical Facility Name]
[License Number]