

Date: [Date]

To: [Employer Name/Human Resources/Vocational Rehabilitation Counselor]

Organization: [Company Name]

Address: [Street Address, City, State, Zip Code]

RE: Vocational Clearance for [Patient Name]

Date of Birth: [Patient DOB]

Date of Evaluation: [Date of Last Exam]

To Whom It May Concern,

I have completed a neurological evaluation and medical record review for [Patient Name]. The purpose of this evaluation was to determine the patient's neurological stability and readiness for [vocational training / returning to work / specific job duties].

Based on my clinical findings and the patient's current neurological status, it is my professional medical opinion that:

[Select one option below]

- The patient is neurologically cleared to return to full-duty work without restrictions.
- The patient is neurologically cleared to return to work with the following specific accommodations or restrictions: [List restrictions, such as lifting limits, screen time limits, or reduced hours].
- The patient is cleared to participate in vocational rehabilitation and training programs.

Current Findings:

[Briefly mention stability of symptoms, e.g., seizure-free interval, cognitive stability, or motor recovery].

Follow-Up Plan:

The patient is scheduled for a follow-up evaluation in [Timeframe]. Should there be any significant change in their neurological condition, this clearance will be re-evaluated.

If you require any additional information regarding this patient's neurological health as it pertains to their vocational activities, please contact my office at [Phone Number].

Sincerely,

[Doctor Signature]

[Doctor Name, MD/DO]

[Board Certification, e.g., Board Certified Neurologist]

[Clinic/Hospital Name]