Date: [Date]

To: [Employer Name/Company Name]
Attn: [Manager or HR Representative Name]
Address: [Company Address]

RE: Workers' Compensation Disability Status - Light Duty Restrictions

Employee Name: [Employee Full Name]
Date of Injury: [Date of Incident]
Claim Number: [Claim Number, if known]

To Whom It May Concern,

I am the treating physician for [Employee Name] regarding a work-related injury. Based on my most recent evaluation on [Date of Last Exam], it has been determined that the patient may return to work in a **Light Duty** capacity effective [Start Date].

The following physical restrictions apply to the patient's work activities until [Expected End Date or Next Evaluation Date]:

- **Lifting/Carrying:** No more than [Number] lbs.
- **Pushing/Pulling:** No more than [Number] lbs. of force.
- **Postural Limits:** No [stooping/kneeling/crouching/climbing].
- **Positional Limits:** Must be allowed to [alternate sitting/standing every 30 minutes].
- **Upper Extremity:** No [repetitive reaching/overhead work/typing] with [left/right/both] arm(s).
- **Other:** [List any additional specific restrictions].

The patient is currently unable to perform their full, regular job duties without these accommodations. Please confirm if your facility can accommodate these temporary restrictions. If these accommodations cannot be met, the patient is to remain off work and maintain Total Temporary Disability (TTD) status.

The patient is scheduled for a follow-up evaluation on [Date of Next Appointment] to reassess their disability status.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Clinic/Facility Name]
[Phone Number]