Date: [Insert Date]

To: [Employer Name / Insurance Carrier]
Attn: [Claims Administrator/HR Manager]
Patient Name: [Employee Full Name]
Claim Number: [Insert Claim #]
Date of Injury: [Insert DOI]

To Whom It May Concern,

I have evaluated [Employee Full Name] regarding the work-related injury sustained on the date referenced above. At this time, the patient's disability status has been updated to **Modified Duty / Partial Disability**.

The patient is cleared to return to work effective [Start Date] with the following physical restrictions:

- **Lifting/Carrying:** No more than [Number] lbs.
- **Standing/Walking:** Maximum [Number] hours per day.
- **Sitting:** Maximum [Number] hours per day.
- **Reaching:** [No overhead reaching / No reaching with left/right arm].
- **Bending/Twisting:** [Limit to occasional / No repetitive bending].
- **Other:** [List any specific environmental or machinery restrictions].

These restrictions are expected to remain in effect until [Date of Next Evaluation/Anticipated End Date].

Please confirm if your facility can accommodate these temporary modifications. If these requirements cannot be met, the patient is to remain off work until further notice.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Medical Facility Name]
[Phone Number]