Date: [Insert Date]

To: [Employer Name/Company Name]

From: [Medical Provider Name/Clinic Name]

Subject: Medical Clearance for Return to Work

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

This letter serves as formal notification that the above-named individual has been under medical care for a diagnosed infectious disease.

The patient has met all clinical criteria for discharge and is no longer considered infectious. In accordance with current public health guidelines and medical assessment, the patient is cleared to return to their regular work duties.

Effective Return Date: [Insert Date]

Work Restrictions:
[ ] No restrictions.
[ ] Modified duties (Specify: [Insert Details])

If you require further information regarding this clearance, please contact our office at [Insert Phone Number].

Sincerely,

[Signature of Medical Professional]

[Printed Name and Title]

[Medical License Number]

[Clinic/Hospital Stamp]