Date: [Date]

To: [Employer Name/Company Name]

From: [Urgent Care Clinic Name]

Subject: Return to Work Medical Clearance

Patient Name: [Patient Full Name]
Date of Birth: [DOB]

To whom it may concern,

The above-named patient was evaluated at our urgent care facility on [Date of Visit].

Work Status (Check one):

- [ ] The patient may return to work with **no restrictions** starting on [Start Date].
- [ ] The patient may return to work with **limited duties/restrictions** from [Start Date] until [End Date].

Specific Restrictions (if applicable):
[List restrictions such as lifting limits, standing limits, or modified hours]

Follow-up Care:
[ ] No follow-up required.
[ ] Patient should follow up with a primary care provider in [Number] days.

If you have any questions regarding this clearance, please contact our office at [Clinic Phone Number].

Sincerely,

_____
Provider Signature

[Provider Name and Title]
[Clinic Name]
[Clinic Address]