Date: [Date]

To: [Employer Name/Company Name]
From: [Physician/Healthcare Provider Name]
Subject: Return to Work Medical Clearance

Patient Name: [Employee Name]
Date of Birth: [DOB]
Date of Injury: [Date of Concussion]

To Whom It May Concern,

[Employee Name] has been under my care for the management of a concussion. Following a clinical evaluation on [Date of Evaluation], I have determined the following regarding their return to work status:

Status (Select One):

- The employee may return to full duty without restrictions as of [Date].
- The employee may return to work with the temporary restrictions listed below from [Start Date] to [End Date].
- The employee is currently unable to return to work and will be re-evaluated on [Date].

Recommended Accommodations/Restrictions (if applicable):

- Reduced work hours (e.g., [Number] hours per day).
- Frequent rest breaks (e.g., 10 minutes every hour).
- Limited screen time/computer use.
- Avoidance of loud environments or bright lights.
- No heavy lifting or strenuous physical exertion.
- Other: [Specific Restriction]

I will continue to monitor [Employee Name]'s progress. If symptoms worsen during the transition back to work, the employee is instructed to notify their supervisor and contact my office immediately.

If you have any questions regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

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