Date: [Insert Date]

To: [Medical Professional Name/Clinic Name]
Address: [Clinic Address]
City, State, Zip: [City, State, Zip]

RE: Authorization for Fitness for Duty Medical Examination

Employee Name: [Employee Full Name]
Date of Birth: [Employee DOB]
Date of Injury: [Date of Injury]

Dear [Doctor Name],

This letter serves as formal authorization for [Employee Name] to undergo a Fitness for Duty (FFD) medical examination following a recent workplace injury. The purpose of this evaluation is to determine the employee's physical and mental capability to perform the essential functions of their job safely.

Requested Services:

- Comprehensive physical examination related to the reported injury.
- Review of the attached Job Description and essential physical requirements.
- Assessment of any necessary work restrictions or accommodations.
- Completion of the attached Work Status Result form.

Please focus your evaluation on whether the employee can return to their regular duties or if a transitional/light-duty assignment is required. Do not provide specific private medical diagnoses that are unrelated to the employee's ability to perform their job tasks.

Billing Information:
Please submit all medical reports and invoices directly to:
[Company Name/Insurance Carrier]
[Attention: Department/Name]
[Billing Address]

If you have any questions regarding the employee's job duties, please contact [Contact Name] at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Printed Name]
[Title]
[Company Name]