[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Employer Name/Human Resources]
Company: [Company Name]
Re: Fitness for Duty Evaluation

Employee Name: [Employee Full Name]
Date of Birth: [DOB]
Job Title: [Job Title]

To Whom It May Concern,

A Fitness for Duty evaluation was performed on the above-named individual on [Date of Evaluation] to determine their physical capability to perform the essential functions of their job description.

Evaluation Results:

[ ] **Fit for Duty:** The employee is physically capable of performing all essential job functions without restrictions.

[ ] **Fit for Duty with Restrictions:** The employee may return to work with the following temporary/permanent limitations:

- Lifting/Carrying: [Limit in lbs]
- Pushing/Pulling: [Limit in lbs]
- Postural (Bending/Stooping/Climbing): [Specific limits]
- Duration/Frequency: [Hours per day or breaks required]
- Other: [Describe other restrictions]

These restrictions are in effect until: [End Date or Follow-up Date]

[ ] **Not Fit for Duty:** The employee is currently unable to perform the essential functions of their position. A re-evaluation is recommended on [Date].

Clinical Notes:
[Optional: Brief comments regarding the physical demands met during testing, such as grip strength, cardiovascular endurance, or range of motion.]

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

Sincerely,

[Physician/Examiner Signature]
[Printed Name and Credentials]
[License Number]