Date: [Date]

To: [Employer Name/Company Name]
Attn: [HR Department/Manager Name]

Subject: Fitness for Duty Medical Clearance

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

To Whom It May Concern,

I have medically evaluated [Employee Name] on [Date of Evaluation] to determine their fitness to return to work following a medical leave of absence.

Based on my clinical examination and the requirements of their job description, I have reached the following conclusion:

Status (Select one):

- The employee is cleared to return to full duty without any restrictions, effective [Date].
- The employee is cleared to return to work with the following temporary restrictions from [Start Date] to [End Date]: [List Restrictions, e.g., no lifting over 10lbs, modified hours, sedentary work only].

I confirm that the employee can perform the essential functions of their position safely at this time.

Please contact my office at [Phone Number] if you require further clarification regarding these medical instructions.

Sincerely,

[Doctor Signature]

[Doctor Name, Title]
[Medical Facility Name]
[License Number]