

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

[Date]

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

RE: RETURN TO WORK AUTHORIZATION

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

To Whom It May Concern,

This letter serves as formal medical authorization for [Employee Name] to return to work following their recent injury.

Please find the status of their return below (check one):

Full Duty: The employee is cleared to return to their regular job duties without any restrictions, effective [Date].

Modified Duty: The employee is cleared to return to work with the following restrictions, effective [Date] through [End Date/Next Evaluation Date]:

- Lifting/Carrying: [e.g., No more than 10 lbs]
- Standing/Walking: [e.g., No more than 2 hours per shift]
- Bending/Squatting: [e.g., Limited or None]
- Other Restrictions: [List specific limitations here]

The employee is scheduled for a follow-up evaluation on [Date]. We will reassess their capabilities and restrictions at that time.

If you have any questions or require further clarification regarding these medical instructions, please contact our office.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]