RETURN TO WORK/SCHOOL
LETTER

To whom it may concern:

_______________________________________________________ was examined and treated in our clinic on _______________________ I am recommending the following based on the patient’s medical condition:

- ☐ No work at all from _________________________ to _______________________
- ☐ Unable to return to work until further evaluation
- ☐ Light work only from ________________________ to _______________________
- ☐ May return to work on ____________ with the following restrictions:
  - ☐ No lifting in excess of ________ lbs.
  - ☐ No repetitive squatting, bending or lifting.
  - ☐ One handed job
  - ☐ This restriction is effective until ______________________
- ☐ May resume full work load/activities effective_______________________
- ☐ No school until ________________________
- ☐ Please excuse ________________________ from work, ________________ he/she had to accompany his/her child to the clinic. (Date)
- ☐ No gymnasium activity or swimming until_____________________________
- ☐ Other_________________________________________________________

Sincerely,

________________________________________________________
Signature Title

________________________________________________________
Department

________________________________________________________
Area code & phone number

SAMPLE