**WORK RESTRICTIONS LETTER FROM DOCTOR**

Date

Doctor Name

Medical Practice or Hospital Name

Street Address

City, ST ZIP Code

Subject: Restriction of working hours of **[Employee Name]**

Dear Name,

I saw (patient’s name) on **(Date)**.

Date of injury and or illness: **(Date)**

The patient named above is medically able to work, but with restrictions on their working hours as of **(Date)**. The patient mentioned earlier is suffering from (**state the illness)**.

Restrictions:

These restrictions should remain in place for around **(weeks of restriction)**.

Date of the next appointment **(Date)**.

I suggest these restrictions based on:

The patient gave information/ My examination as well as an assessment of the patient **(tick which one)**.

I have given this form to the above patient.

Sincerely,

Physician’s signature