Post-Surgery Work Restriction Letter

Date:

To:

Employee Name:

Employee Position / Department:

This letter serves to confirm that the above-named individual recently underwent surgical intervention and is currently under my medical care. Please note the following work restrictions as part of their post-surgery recovery:

Work Restrictions:

Duration of Restrictions:

Date Employee May Return to Full Duty:

Additional Notes:

Physician's Signature

Physician Name & Contact Information: