

**Date:** [Insert Date]

**To Whom It May Concern,**

This letter is to certify that **[Patient Name]**, date of birth **[DOB]**, has met the requirements for clearance following a COVID-19 infection or exposure.

The individual underwent testing for SARS-CoV-2 on **[Test Date]** and received a **NEGATIVE** result. Based on current health guidelines and the resolution of symptoms, **[Patient Name]** is no longer considered contagious.

As of **[Clearance Date]**, the patient is cleared to return to:

- Work
- School
- General Public Activities

If you require further verification or have additional questions regarding this clearance, please contact our office at **[Phone Number]**.

Sincerely,

[Provider Name/Signature]  
[Title/Medical Credentials]  
[Clinic/Facility Name]