

[Clinic Name]
[Clinic Address]
[Phone Number]
[Email Address]

Date: [Current Date]

RE: MEDICAL CLEARANCE FOR RETURN TO WORK/SCHOOL

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

This letter serves to certify that [Patient Name] has been evaluated by our clinic following a COVID-19 infection.

The patient has met the following criteria for clearance:

- At least [Number] days have passed since the onset of symptoms or the date of the positive test.
- The patient has been fever-free for at least 24 hours without the use of fever-reducing medications.
- Other symptoms (e.g., cough, shortness of breath) have significantly improved.
- The patient is currently asymptomatic and is no longer considered contagious.

Based on current public health guidelines, [Patient Name] is medically cleared to return to normal activities, including work and school, effective [**Return Date**]. No further testing is required for this return.

If you require any further information, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Name, Title]
[License Number]
[Clinic Stamp]