

**Date:** [Date]

**To:** [Employer Name / Facility Name]

**From:** [Healthcare Provider Name / Clinic Name]

**Subject:** Medical Clearance for Return to Work

To Whom It May Concern,

This letter is to certify that **[Patient Name]** has been under my medical care for a foodborne illness.

The patient has met the following criteria for recovery:

- Symptoms (including vomiting and diarrhea) have resolved.
- The patient has been symptom-free for at least [Number, e.g., 24 or 48] hours without the use of medication.
- [Optional: Negative lab results have been confirmed, if required by local health codes.]

Based on my clinical evaluation, [Patient Name] is no longer considered infectious and is cleared to return to work in a food-handling capacity effective **[Return Date]**.

The patient has been educated on proper handwashing techniques and hygiene protocols to prevent future occurrences.

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

Sincerely,

[Signature of Healthcare Provider]

[Printed Name and Title]

[Medical License Number]

[Clinic/Hospital Stamp]