[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To [Name of School Principal or Section 504 Coordinator],

Re: [Student Name]
DOB: [Date of Birth]

I am the treating physician for [Student Name]. Due to a documented medical condition, it is my clinical recommendation that [Student Name] undergo a graduated, partial-day return to school to ensure a safe and sustainable recovery.

Effective [Start Date], I recommend the following schedule:

- **Current Capacity:** [Number] hours per day.
- **Arrival/Departure Time:** [Specific Time Range, e.g., 8:00 AM to 11:30 AM].
- **Duration:** This partial schedule should remain in place until [Date or Re-evaluation Date].

While at school, the student requires the following accommodations:

- [Accommodation 1, e.g., Rest breaks as needed]
- [Accommodation 2, e.g., Modified workload or extended deadlines]
- [Accommodation 3, e.g., Access to nursing staff]

We will monitor [Student Name]'s progress and provide updated documentation when they are medically cleared to increase their school hours. Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

[Physician Signature]

[Physician Name, Credentials]