Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Date of Injury/Surgery: [Date]

To Whom It May Concern,

This letter serves as formal medical clearance for the patient listed above. [Patient Name] has been under my orthopedic care for the treatment of [Specific Injury or Procedure].

Based on my clinical evaluation and the patient's progress during rehabilitation, I have determined that they have reached maximum medical improvement regarding this condition. The patient is now cleared for **full, unrestricted activity resumption**, effective [Start Date].

This clearance includes, but is not limited to:

- Full participation in competitive sports and athletics.
- Heavy lifting and manual labor without weight restrictions.
- High-impact aerobic exercises and training.
- Full-duty work requirements.

There are no further physical limitations or modifications required at this time. Should the patient experience a recurrence of symptoms or a new injury, they are instructed to follow up with my office immediately.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Practice/Clinic Name]
[Phone Number]
[Email Address]