Date: [Date]

To: [School Name/Administration]
From: [Provider Name, Credentials]
Subject: Return to School Clearance with Partial Accommodations

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

To Whom It May Concern,

I have been treating [Student Name] following a recent mental health crisis. I have evaluated the student and determined that they are clinically stable and cleared to return to school effective [Date].

To ensure a successful transition and prevent a recurrence of symptoms, I am recommending the following partial accommodations for a period of [Duration/Until Next Review Date]:

- **Modified Schedule:** [e.g., Half-day attendance or late start].
- **Workload Reduction:** [e.g., Exemption from non-essential assignments or extended deadlines].
- **Testing Accommodations:** [e.g., Testing in a quiet room or extended time].
- **Rest Breaks:** [e.g., Permission to visit the counselor's office or a designated "safe space" as needed].
- **Physical Education:** [e.g., Participation as tolerated or temporary exemption].

The student is currently [taking/not taking] medication that may cause side effects such as [Side Effects, if applicable].

I will continue to monitor the student's progress. We will re-evaluate these accommodations on [Follow-up Date] to determine if they can be phased out or if further support is required.

If you have any questions or require further documentation, please contact my office at [Phone Number].

Sincerely,

[Signature]

[Printed Name]
[Title/License Number]
[Clinic/Agency Name]