

**Date:** [Date]

**To:** [School Name / Administrator Name]

**From:** [Provider Name/Clinical Director]

**Facility:** [IOP Program Name]

**RE: Return to School Clearance**

**Student Name:** [Student Full Name]

**Date of Birth:** [DOB]

To Whom It May Concern,

This letter serves to confirm that [Student Name] has been receiving treatment at [IOP Program Name] for an intensive outpatient mental health crisis intervention. The student has been under our clinical care from [Start Date] to [End Date].

Based on our clinical assessment, the student is medically and psychiatrically cleared to return to school effective [Return Date].

**Recommended Academic Accommodations (if applicable):**

- [e.g., Reduced course load for first week]
- [e.g., Access to counselor's office for breaks]
- [e.g., Extended deadlines for missed assignments]

The student will continue to participate in our outpatient program on the following schedule: [Schedule Details].

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

Sincerely,

[Signature]

[Printed Name and Credentials]

[Title]