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

To: [School Name/Office of Disability Services]

RE: Return to School Clearance and Academic Accommodations for [Student Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

This letter is to certify that [Student Name] has been under my clinical care following a mental health crisis that began on [Start Date]. After a clinical evaluation, I have determined that the student is medically cleared to return to their academic studies effective [Return Date].

To support the student's successful reintegration and ensure their ongoing stability, I recommend the following academic modifications and accommodations:

- [e.g., Gradual return to full-time course load]
- [e.g., Extensions on assignments missed during the crisis period]
- [e.g., Permission to take frequent breaks during classes or exams]
- [e.g., Testing in a quiet, low-distraction environment]
- [e.g., Access to excused absences for ongoing therapy appointments]

In my professional opinion, these modifications are necessary to mitigate the impact of the student's condition on their academic performance during this recovery period. We will re-evaluate the need for these accommodations on [Review Date].

If you require further information or have questions regarding these recommendations, please contact my office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Printed Name]
[Credentials/License Number]