

Date: [Insert Date]

To: [Recipient Name/Organization Name]

Subject: Medical Clearance for Reinstatement

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Dear [Recipient Name or Title],

This letter is to confirm that [Patient Name] was seen at [Clinic Name] on [Date of Visit] for a gastrointestinal illness.

The patient has been evaluated and is no longer exhibiting symptoms. In accordance with clinical guidelines, the patient has been symptom-free for at least [Number, e.g., 24 or 48] hours and is no longer considered contagious.

Therefore, [Patient Name] is medically cleared to return to [Work/School/Childcare] effective [Return Date].

There are no specific restrictions or accommodations required at this time. We continue to advise the practice of thorough hand hygiene to prevent the spread of illness.

If you have any questions regarding this clearance, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Name, Credentials]

[Clinic Name]

[Clinic Address]