[Physician Name/Clinic Name]
[Address]
[Phone Number]
[Date]

To Whom It May Concern,

This letter is to certify that [Student Name] was under my care for a surgical procedure performed on [Date].

The student is cleared to return to school on [Date]. Please note the following restrictions for a period of [Number] weeks:

- No physical education (PE) or sports.
- No heavy lifting (limit to [Number] lbs).
- Allow extra time for transitions between classes.

If you have any questions, please contact our office.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Physician Name/Clinic Name]
[Date]

RE: Medical Necessity for Elevator Access

To the Administration of [School Name]:

Please provide [Student Name] with an elevator pass and access to school elevators effective immediately. Due to [recent surgery/medical condition], the student is unable to navigate stairs safely at this time.

This accommodation is required until [Date] or until further clinical evaluation.

Thank you for your assistance in ensuring the student's safety.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]