Date: [Date]

To: Dive Training Professional / Dive Center

Subject: Medical Clearance for Scuba Diving

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]

To whom it may concern,

I have examined the above-named patient on [Examination Date] to evaluate their fitness for participate in recreational scuba diving activities.

During my evaluation, I reviewed the patient's medical history and conducted a physical examination in accordance with the RSTC (Recreational Scuba Training Council) medical standards.

Based on my clinical findings, it is my professional opinion that:

[ ] The patient is MEDICALLY FIT to engage in recreational scuba diving without restrictions.

[ ] The patient is NOT MEDICALLY FIT to engage in recreational scuba diving at this time.

Comments/Restrictions:
[Insert comments or leave blank]

Sincerely,

Physician Signature: _____
Physician Name: [Doctor Name]
Medical License Number: [License #]
Facility Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]