Date: [Insert Date]

To: Dive Instructor / Dive Center Manager

Subject: Conditional Medical Clearance for Scuba Diving

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]

To whom it may concern,

I have performed a medical evaluation of the patient named above regarding their fitness to participate in recreational scuba diving. Based on my assessment and the patient's medical history, I find the patient **medically fit to dive**, subject to the following specific **conditions and limitations**:

- **Depth Limitation:** Not to exceed [Insert Depth, e.g., 18 meters/60 feet].
- **Environmental Conditions:** To dive only in [e.g., warm water / calm conditions / no strong currents].
- **Exertion Level:** Patient must avoid strenuous underwater activity or heavy lifting on deck.
- **Medication Requirement:** Patient must adhere to the following medication schedule: [Insert Details].
- **Supervision:** Patient must be accompanied by a [e.g., Divemaster or higher-rated professional] at all times.
- **Other Restrictions:** [Insert any other specific medical caveats].

This clearance is valid until [Insert Expiration Date], provided there are no changes to the patient's health status in the interim. If the patient experiences any symptoms such as chest pain, shortness of breath, or neurological changes, they must cease diving immediately and seek re-evaluation.

Please feel free to contact my office if you require further clarification.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical License Number]
[Clinic/Hospital Name]
[Phone Number]