Date: [Insert Date]

To: [Dive Center Name / Instructor Name / Training Agency]

Subject: Medical Clearance for Recreational/Professional Scuba Diving

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

To whom it may concern,

I have performed a physical examination of the patient named above on [Insert Date of Exam]. During this evaluation, I reviewed the patient's medical history and assessed their fitness to participate in underwater diving activities.

Based on my findings and the medical guidelines for diving (such as the RSTC/UHMS standards), I find the patient to be:

[ ] CLEAR - I find no medical conditions that I consider incompatible with diving.

[ ] NOT CLEAR - I find medical conditions that present unacceptable risks for diving.

Restrictions/Comments (if any):
[Insert any specific limitations or leave blank]

Sincerely,

Physician Signature: _____
Physician Name: [Insert Full Name]
Medical License Number: [Insert License #]
Clinic/Hospital Name: [Insert Clinic Name]
Contact Phone: [Insert Phone Number]
Email: [Insert Email Address]

[Clinic Stamp/Seal Here]