Date: [Insert Date]

To: Dive Training Professional / Dive Center

Subject: Medical Clearance for Recreational Scuba Diving

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

To whom it may concern,

I have reviewed the **RSTC (Recreational Scuba Training Council) Medical Participant Questionnaire** completed by the patient named above. I have also performed a physical examination and reviewed their medical history in relation to the physical demands and physiological risks of recreational scuba diving.

Based on my evaluation, I find this individual:

[ ] CLEAR: I find no medical conditions that I consider incompatible with recreational scuba diving.

[ ] NOT CLEAR: I find medical conditions that represent unacceptable hazards to the patient's safety while diving.

Clinical Comments (if any):
[Insert any restrictions or notes here]

Physician Information:

Physician Name: [Insert Name]
Medical Degree/Specialty: [Insert Degree]
License Number: [Insert Number]
Clinic/Hospital: [Insert Clinic Name]
Phone Number: [Insert Phone Number]
Email: [Insert Email]

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Physician Signature