To: Dive Training Organization / Dive Professional

Date: [Insert Date]

Subject: Pulmonary Medical Clearance for Scuba Diving

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

To whom it may concern,

I have performed a pulmonary medical assessment on the above-named patient to evaluate their fitness for participation in recreational scuba diving. My evaluation included a review of their medical history, a physical examination, and [Insert specific tests, e.g., Spirometry, Peak Flow, or Chest X-ray if performed].

Based on this assessment and the current medical standards for diving (such as those established by the Undersea and Hyperbaric Medical Society), I have reached the following conclusion:

[Select One Option]

- [ ] The patient has no pulmonary contraindications and is **CLEARED** for scuba diving.
- [ ] The patient is **NOT CLEARED** for scuba diving at this time.

Comments/Restrictions: [Insert any specific notes or leave blank]

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]
[Contact Phone Number]
[Email Address]