Date: [Date]

To: Dive Training Agency / Dive Operator

Subject: Medical Clearance for Scuba Diving

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

To whom it may concern,

I am the physician responsible for the care of [Patient Name], who underwent [Type of Surgery] on [Date of Surgery].

I have evaluated the patient's recovery progress and physical condition. The surgical site is fully healed, and there are no remaining complications, functional limitations, or contraindications related to the pressure changes and physical demands associated with recreational scuba diving.

I confirm that the patient is medically fit to resume scuba diving activities without restrictions as of [Effective Date].

If you require any further information, please contact my office.

Sincerely,

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