Date: [Insert Date]

To: Scuba Diving Instructor / Dive Center Manager

Subject: Temporary Medical Restriction and Clearance for Scuba Diving

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

To whom it may concern,

I have medically evaluated the above-named patient regarding their fitness to participate in recreational scuba diving. The patient was previously restricted from diving due to: [Insert Brief Description of Condition/Injury].

At this time, I find the patient to be: **[Select One: Fit to Dive / Unfit to Dive]**.

Current Restrictions or Limitations:
[Insert "None" or specify, e.g., Depth limit, duration limit, or required rest periods]

Clearance Duration:
This medical clearance is valid until: [Insert Expiration Date].

I have discussed the potential risks of scuba diving relative to the patient's medical history. The patient understands these risks and has been advised to seek further medical evaluation should their symptoms return or their health status change.

Sincerely,

Physician Signature: _____
Physician Name: [Insert Name and Credentials]
Medical License Number: [Insert License Number]
Clinic/Hospital Name: [Insert Facility Name]
Contact Phone: [Insert Phone Number]