Date: [Insert Date]

To: [Dive Center/Insurance Provider Name]

Subject: Medical Clearance for Scuba Diving - [Diver's Full Name]

Diver Information:
Name: [Full Name]
Date of Birth: [Date of Birth]
Age: [Age]

To whom it may concern,

I am a licensed physician currently treating [Diver's Name]. I have reviewed the patient's medical history and conducted a physical evaluation in accordance with the RSTC (Recreational Scuba Training Council) Medical Statement guidelines.

Given the diver's age, specific attention was paid to cardiovascular health, respiratory function, and neurological status. I find the patient to be in good general health and physically capable of performing the activities associated with recreational scuba diving.

Medical Clearance Status:

[ ] The patient is **CLEARED** to dive with no restrictions.
[ ] The patient is **CLEARED** to dive with the following limitations: [List limitations if any].
[ ] The patient is **NOT CLEARED** to dive.

This clearance is valid until [Insert Expiration Date, typically 12 months from today].

Sincerely,

Physician Name: [Name and Title]
Medical License Number: [License Number]
Clinic/Hospital: [Facility Name]
Phone Number: [Phone Number]
Email: [Email Address]

Physician Signature: _____

Official Stamp: