[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Recipient Name/Organization Name]
Re: Vision Medical Clearance for [Patient Full Name]

To Whom It May Concern,

I have completed a comprehensive vision evaluation for [Patient Full Name], date of birth [DOB], on [Date of Exam].

Evaluation Results:

- Visual Acuity (Right Eye): [Result]
- Visual Acuity (Left Eye): [Result]
- Visual Acuity (Both Eyes): [Result]
- Field of Vision: [Normal/Restricted]
- Color Vision: [Normal/Deficient]

Correction Requirements:
[ ] No corrective lenses required.
[ ] Corrective lenses (glasses/contacts) required for [Task/All Times].

Medical Clearance Status:
Based on the clinical findings, I certify that the patient is:
[ ] Medically cleared without restrictions.
[ ] Medically cleared with the following restrictions: [List Restrictions].
[ ] Not cleared at this time.

This clearance is valid until [Expiration Date].

Sincerely,

[Physician Signature]

[Physician Name, Title]
[License Number/NPI]