Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Injury Date: [Date of Injury]
Diagnosis: [Specific Injury Diagnosis]

To Whom It May Concern,

This letter is to certify that [Patient Name] has been under my care for the orthopedic injury listed above. After a clinical evaluation and a review of the patient's progress, I have determined the following regarding their return to sports and physical activities:

Clearance Status (Check One):

[ ] **Full Clearance:** The patient is cleared to return to full, unrestricted competitive play and practice effective [Date].
[ ] **Modified Clearance:** The patient may return to activity with the following restrictions: [List Restrictions] until [Date].
[ ] **Gradual Return:** The patient should follow a graduated return-to-play protocol starting on [Date].

Required Equipment:
[ ] No special equipment required.
[ ] Patient must wear a brace/support: [Type of Brace] during all athletic activities.

The patient has demonstrated sufficient strength, range of motion, and functional stability to safely resume these activities. Please feel free to contact my office if you require further information.

Sincerely,

Provider Signature: _____

Provider Name: [Doctor Name, Title]
Clinic Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]