Date: [Date]

To: [Coach Name/Athletic Department]
Organization: [School/Team Name]

RE: Medical Clearance for [Athlete Full Name]
Date of Birth: [Date of Birth]
Date of Surgery: [Surgery Date]
Procedure: [Type of Surgery]

To Whom It May Concern,

This letter is to confirm that [Athlete Name] has been under my care following their recent surgical procedure. After a clinical evaluation and assessment of their recovery progress, I am providing the following recommendations regarding their return to athletic activities:

Clearance Status (Check One):

- [ ] **Full Clearance:** The athlete is cleared for full, unrestricted participation in all sports and competitive activities, including contact sports, effective [Date].
- [ ] **Modified Clearance:** The athlete is cleared to participate with the following restrictions: [List restrictions, e.g., no contact, weight limits].
- [ ] **Phased Return:** The athlete may begin a graduated return-to-play protocol starting with [Specific activity] on [Date].

Specific Instructions/Precautions:
[Insert specific instructions or "None"]

The athlete is scheduled for a follow-up appointment on [Follow-up Date]. Please do not hesitate to contact my office at [Phone Number] if you require further clarification.

Sincerely,

Physician Signature: _____

Physician Name: [Doctor's Full Name]
Medical License #: [License Number]
Clinic/Hospital: [Facility Name]