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

To Whom It May Concern,

RE: Patient Medical Clearance

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]

I am the treating physician for [Patient Name], who is currently under my care for the management of the following chronic condition(s): [List Conditions, e.g., Type 2 Diabetes, Hypertension, Asthma].

As of [Date of Last Evaluation], the patient's condition is considered stable and well-managed through [Medication/Treatment Plan]. At this time, the patient is medically cleared to participate in [Specific Activity, e.g., physical exercise, employment duties, travel] with the following restrictions or considerations:

- [Restriction 1 or "None"]
- [Restriction 2 or "None"]

The patient has been advised to continue their prescribed treatment and follow up in my office on [Next Appointment Date].

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]