Date: [Insert Date]

To: [Cruise Line Name] Medical Department / Special Services

Subject: Medical Clearance for Travel and Mobility Assistance

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Booking Reference: [Reservation Number]
Ship Name: [Ship Name]
Sailing Dates: [Departure Date] to [Return Date]

To Whom It May Concern,

I am the primary healthcare provider for the above-named patient. I am writing to confirm that I have evaluated the patient and find them fit to travel on the scheduled cruise mentioned above.

Medical Condition:
The patient has the following diagnosis/condition requiring mobility assistance: [Insert Diagnosis/Condition].

Mobility Requirements:
The patient requires the use of the following equipment (please check/list all that apply):
- [ ] Manual Wheelchair
- [ ] Power Wheelchair / Mobility Scooter (Dimensions: [Length] x [Width], Battery Type: [Dry Cell/Gel/Lithium])
- [ ] Walker / Rollator
- [ ] Oxygen Concentrator (Model: [Model Name])

Functional Limitations & Assistance Needed:
- Patient requires an accessible stateroom: [Yes/No]
- Patient requires assistance during embarkation/debarkation: [Yes/No]
- Patient is able to navigate small steps or short distances independently: [Yes/No]
- Patient is capable of self-evacuating in an emergency with the assistance of their mobility device: [Yes/No]

Medications:
The patient is compliant with their medical regimen. A full list of medications is attached if required.

In my professional opinion, the patient is medically stable for the duration of this voyage. If you require further information, please contact my office at the number listed below.

Sincerely,

[Physician Signature]

Physician Name: [Printed Name]
Medical License Number: [License #]
Clinic/Hospital: [Facility Name]
Phone Number: [Phone Number]
Email: [Email Address]