Date: [Insert Date]

To: Medical Department, [Insert Cruise Line Name]

Subject: Medical Clearance for Cruise Travel

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Booking Reference: [Insert Booking Number]

To Whom It May Concern,

I am the primary healthcare provider for the above-named patient, who is under my care for the following respiratory condition(s): [Insert Condition, e.g., COPD, Asthma, Pulmonary Fibrosis].

I have reviewed the patient's current health status and the requirements of cruise travel. I certify that the patient is clinically stable and fit to travel on a cruise ship for the duration of [Insert Number] days, starting [Insert Departure Date].

Medications and Equipment:
The patient is required to carry the following medications and/or medical equipment:

- [List Medication/Inhalers]
- [Specify Oxygen Requirements, e.g., Portable Oxygen Concentrator (POC)]
- [Specify CPAP/BiPAP settings if applicable]

Stability Statement:
The patient has not been hospitalized for their respiratory condition within the last [Insert Number] months and does not currently require acute medical intervention. They are capable of performing activities of daily living and can navigate the ship's environment independently or with the assistance of their travel companion.

Physician Contact Information:
Name: [Insert Physician Name]
Title: [Insert Title/Specialty]
Clinic/Hospital: [Insert Facility Name]
Phone: [Insert Phone Number]
Email: [Insert Email Address]

Sincerely,

[Signature]

[Printed Name and Medical License Number]