Date: [Insert Date]

To: [Surgeon Name]
Department: [Surgical Department/Hospital Name]
Fax/Email: [Insert Contact Information]

RE: Unconditional Medical Clearance for Surgery

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Proposed Procedure: [Name of Surgery]

To Whom It May Concern,

I have evaluated the above-named patient to determine their medical readiness for the proposed surgical procedure. Based on my clinical examination, review of medical history, and recent diagnostic findings, the patient is in stable condition.

I provide **unconditional medical clearance** for the patient to proceed with the scheduled surgery under general anesthesia. There are no active medical contraindications or specific restrictions required from a primary care or internal medicine standpoint.

The patient has been instructed on the management of their chronic medications during the perioperative period. No further preoperative testing is required at this time.

If you require any additional information, please contact my office directly.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Phone Number]