[Date]

[Recipient Name/Department]
[Organization/Institution Name]
[Address Line 1]
[City, State, Zip Code]

RE: Immunization Verification and Clearance for [Patient Full Name]

To Whom It May Concern,

This letter serves to certify that **[Patient Full Name]**, date of birth **[DOB]**, has been evaluated by this facility regarding their immunization status.

Based on a review of the patient's medical records and/or recent laboratory titers, the following vaccinations are up to date and meet the requirements for [School/Work/Travel]:

- MMR (Measles, Mumps, Rubella)
- Varicella (Chickenpox)
- Tdap (Tetanus, Diphtheria, Pertussis)
- Hepatitis B
- Meningococcal
- Influenza (Current Season)
- [Additional Vaccine Name]

The patient has been cleared for full participation in all activities, duties, or clinical rotations without restrictions.

Should you require further documentation or have questions regarding these records, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Name, Title/Credentials]
[Clinic/Facility Name]
[Medical License Number]