Date: [Insert Date]

To: [Recipient Name/Organization]
Department: [Insert Department Name]
Address: [Insert Address]

Subject: Medical Clearance for Program Enrollment

To Whom It May Concern,

This letter serves to confirm that **[Patient Name]** (DOB: [Patient Date of Birth]) is currently under my care for the management of the following chronic condition(s):

- [Insert Condition 1]
- [Insert Condition 2]

I have reviewed the requirements for enrollment in the **[Name of Program/Plan]**. Based on my most recent clinical evaluation, the patient is medically stable and cleared to participate in this program.

Clinical Recommendations & Limitations:

- [Insert specific restrictions or "No restrictions"]
- [Insert medication requirements if applicable]

This clearance is valid until [Insert Expiration Date or "further notice"]. Should there be any significant change in the patient's medical status, I will provide an updated assessment.

If you require further clinical information, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Facility Name]