Date: [Insert Date]

To: [Employer/Establishment Name]
Address: [Insert Address]

Subject: Annual Routine Assessment - Food Handler Medical Clearance

To whom it may concern,

This is to certify that I have performed a clinical examination and medical assessment of **[Employee Name]**, Date of Birth: **[Insert DOB]**, for their annual food handler routine check-up.

The assessment included a review of medical history and a physical examination to screen for communicable diseases that can be transmitted through food, including but not limited to skin infections, respiratory infections, and gastrointestinal illnesses.

Based on the findings of this assessment, the individual is found to be:

[ ] Fit for Duty: The individual shows no clinical signs of infectious or communicable diseases and is cleared to handle food in a commercial environment.

[ ] Not Fit for Duty: The individual is currently restricted from food handling duties until further notice or treatment is completed.

This clearance is valid until: **[Insert Expiration Date]**.

Sincerely,

[Signature]
[Doctor's Name/Medical Examiner]
[Medical License Number]
[Clinic/Hospital Name]
[Contact Information]