Date: [Insert Date]

To: [Employer Name / Establishment Name]

Subject: Medical Clearance for Food Handling Duties

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]

To Whom It May Concern,

This letter serves to certify that the above-named individual has been evaluated following a gastrointestinal illness.

The patient has reported a complete resolution of symptoms, including vomiting and diarrhea, for a period of at least [Insert Number, e.g., 24 or 48] hours without the use of symptom-masking medication.

Based on my clinical evaluation and the current public health guidelines for food handlers, it is my professional opinion that this individual is no longer considered a transmission risk and is medically cleared to return to work and resume all food handling duties effective [Insert Return Date].

If any further information is required, please contact my office directly.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Facility Name]
[Phone Number]