Date: [Insert Date]

To: [Skydiving Center/School Name]

Subject: Medical Clearance for Skydiving Participation

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

To Whom It May Concern,

I am a licensed physician currently treating the above-named individual. I have reviewed the physical requirements and potential stresses associated with intentional parachute jumping (skydiving), which include rapid altitude changes, physical exertion, and landing impacts.

Based on my medical evaluation of the patient on [Date of Last Exam], it is my professional opinion that they are medically fit to participate in skydiving activities.

This clearance is subject to the following limitations or remarks (if any):
[Insert Limitations or "None"]

Please feel free to contact my office at [Insert Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, M.D./D.O.]
[Medical License Number]
[Clinic/Hospital Name]
[Address]