Date: [Date]

To: Dive Medical Officer / Scuba Instructor

Subject: Medical Clearance for Scuba Diving

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

To whom it may concern,

I have performed a medical evaluation of the patient named above regarding their fitness to participate in recreational scuba diving. My evaluation included a review of their medical history and a physical examination.

Based on my findings and current diving medical standards, I find this individual:

[ ] **MEDICALLY FIT:** I find no medical conditions that I consider incompatible with scuba diving.
[ ] **MEDICALLY UNFIT:** I find medical conditions that may present an unacceptable risk to the patient during diving activities.

Specific Restrictions or Comments (if any):
[Insert comments here]

Sincerely,

Physician Signature: ___________________________
Physician Name: [Doctor's Full Name]
Medical License Number: [License Number]
Clinic/Hospital Name: [Facility Name]
Phone Number: [Phone Number]