Date: [Date]

To: [Name of Equine Center/Program]
Address: [Program Address]

RE: Therapeutic Horseback Riding Medical Clearance

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

To whom it may concern,

I am writing to provide medical clearance for my patient, [Patient Name], to participate in a therapeutic horseback riding program. I have reviewed the patient's medical history and current physical condition.

Diagnosis/Medical Condition: [List relevant diagnoses]

Precautions or Contraindications: [List any specific limitations, such as spinal issues, seizures, or hip instability, or write "None"]

Based on my evaluation, I find no medical reasons why this patient should not participate in equine-assisted activities. In my professional opinion, the patient is physically and mentally stable enough to engage in this activity under the supervision of certified instructors.

This clearance is valid until [Expiration Date/1 Year from Today]. Please feel free to contact my office if you require further information.

Sincerely,

[Physician Signature]
Physician Name: [Print Name]
Medical License Number: [License #]
Phone Number: [Office Phone]
Clinic Name: [Clinic/Hospital Name]