Date: [Insert Date]

To: [Insert Racing Authority/Licensing Board Name]
Attn: Medical Department / Licensing Office

RE: ANNUAL MEDICAL CLEARANCE FOR PROFESSIONAL JOCKEY

Jockey Name: [Insert Full Name]
Date of Birth: [Insert Date of Birth]
License Number: [Insert License Number, if applicable]

To the Licensing Committee,

I, Dr. [Insert Physician Name], have performed a comprehensive physical examination on the above-named individual on [Insert Examination Date] to determine their fitness for professional horse racing.

The examination included an assessment of the following:

- Cardiovascular health and blood pressure
- Neurological function and concussion history
- Visual acuity and hearing
- Musculoskeletal strength and range of motion
- Review of current medications and chronic conditions

Based on my clinical findings and the specific physical demands of professional race riding, I certify that [Insert Jockey Name] is:

[ ] MEDICALLY FIT to compete in professional horse racing without restrictions.
[ ] MEDICALLY FIT to compete with the following restrictions: [Insert Restrictions]
[ ] NOT MEDICALLY FIT to compete at this time.

This clearance is valid until [Insert Expiration Date, typically one year from exam].

Sincerely,

[Signature]
[Insert Physician Name, MD/DO]
[Insert Medical License Number]
[Insert Clinic/Hospital Name]
[Insert Phone Number]
[Insert Email Address]