Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Injury Date: [Insert Date of Injury]
Diagnosis: [Insert Diagnosis/Injury Type]

To Whom It May Concern,

[Patient Name] has been under my orthopedic care following the injury noted above. After a clinical evaluation and review of the patient's recovery progress, I have determined the following regarding their return to equestrian activities:

Clearance Status:

- [ ] Full clearance for all equestrian activities (riding, jumping, grooming, and stable work).
- [ ] Partial clearance with specific restrictions (listed below).
- [ ] Not cleared for riding; ground-work only.

Specific Restrictions or Graduated Return Plan:
[Insert specific instructions, e.g., "No jumping for 4 weeks," "Limit riding to 20 minutes of walking only," "Avoid lifting more than 20lbs"]

Equipment Recommendations:
[Insert requirements, e.g., "Must wear a safety vest," "Use of an ankle brace required," "Standard safety helmet"]

The patient has demonstrated sufficient strength, range of motion, and balance to resume these activities safely. I recommend a gradual return to full intensity based on the patient's pain levels and physical tolerance.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Medical License Number]