Date: [Insert Date]

To: [Recipient Name/Organization/Stable Name]

Subject: Medical Clearance for Equestrian Activities

Patient Name: [Rider's Full Name]
Date of Birth: [Rider's DOB]

To Whom It May Concern,

I have recently performed a health evaluation for the above-named patient to determine their physical fitness for equestrian activities. Based on this clinical assessment, I find the patient to be in stable health and physically capable of participating in horseback riding.

Evaluation Summary:

- **Range of Motion:** Adequate for mounting, dismounting, and maintaining balance.
- **Cognitive Function:** Within normal limits for following safety instructions and managing a horse.
- **Cardiovascular Status:** Stable for moderate physical exertion.
- **Vision/Hearing:** Sufficient (with or without correction) for safe arena or trail riding.

Recommended Restrictions or Accommodations:
[Insert "None" or specify, e.g., Use of a mounting block required, limited to walking pace, etc.]

This clearance is valid for [Insert Time Period, e.g., 12 months] from the date of this letter, provided there are no significant changes in the patient's medical status.

If you have any questions or require further information, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]
[Contact Address]