Date: [Insert Date]

To: [Fertility Clinic Name]
Attn: [Physician Name/Medical Records]
Address: [Clinic Address]

RE: Infectious Disease Medical Clearance for In Vitro Fertilization (IVF)

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

To Whom It May Concern,

I am writing to provide medical clearance for the above-named patient to proceed with In Vitro Fertilization (IVF) and/or assisted reproductive technology (ART) treatments.

The patient has undergone a comprehensive evaluation and screening for infectious diseases as required by clinical guidelines. Based on the results dated [Insert Date of Results], the following statuses have been confirmed:

- **HIV 1/2:** [Negative/Non-reactive]
- **Hepatitis B (HBsAg):** [Negative/Non-reactive]
- **Hepatitis C (HCV Ab):** [Negative/Non-reactive]
- **RPR (Syphilis):** [Non-reactive]
- **[Optional: Other]:** [Result]

At this time, there is no evidence of active or chronic infectious disease that would pose a contraindication to fertility treatment, egg retrieval, or pregnancy. The patient is considered medically stable from an infectious disease standpoint for the intended procedures.

Should you have any questions or require further documentation regarding these results, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Board Certification/Specialty]
[Practice Name]
[Contact Information]