[Hospital/Transplant Center Name]
[Transplant Department]
[Street Address]
[City, State, Zip Code]

[Date]

RE: Medical Clearance for Living Kidney Donation
Donor Name: [Full Name of Donor]
Date of Birth: [DOB]

To Whom It May Concern,

The above-named individual has completed a comprehensive medical, surgical, and psychosocial evaluation at [Hospital Name] to determine their suitability for living kidney donation.

Based on the results of the laboratory tests, diagnostic imaging, and clinical consultations, [Donor Name] has been found to be in good health and meets the medical criteria for kidney donation. There are no identified contraindications to proceeding with the donor nephrectomy at this time.

The donor has been informed of the potential risks and long-term implications of the procedure and has provided informed consent. We have cleared this individual for the donation procedure scheduled for [Date, if known, otherwise "a date to be determined"].

If you require any additional information regarding this clearance, please contact the Transplant Coordinator at [Phone Number].

Sincerely,

[Signature]

[Name of Transplant Nephrologist/Surgeon]
[Title]
[License Number]