[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Employer Name/HR Department or Military Branch Liaison]
Subject: Medical Clearance for Covered Servicemember Caregiver

To Whom It May Concern,

This letter is to certify that **[Caregiver's Full Name]** is currently providing necessary care for **[Servicemember's Full Name]**, who is a covered servicemember/veteran with a serious injury or illness incurred in the line of duty.

Patient Status:
The patient is currently undergoing treatment and rehabilitation for a medical condition that requires assistance with basic medical, hygienic, nutritional, or safety needs, as well as transportation for medical appointments.

Duration of Care:
It is my professional medical opinion that the caregiver's assistance is required from **[Start Date]** through approximately **[End Date]**. The care required is [Continuous / Intermittent].

Clinical Clearance:
I certify that the caregiver is physically and mentally capable of performing the duties required to assist the patient during this period. There are no medical restrictions preventing the caregiver from fulfilling these responsibilities.

Should you require further information regarding the necessity of this care, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]
[Clinic Stamp/Seal]