Date: [Date]

To: [Airline/Transportation Provider/Event Organizer Name]

Subject: Medical Clearance for Mobility Assistance and Wheelchair Accommodation

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Reference/Booking Number (if applicable): [Reference Number]

To Whom It May Concern,

I am writing to confirm that [Patient Name] is currently under my medical care. Due to a physical disability/medical condition, the patient requires specific mobility assistance and wheelchair accommodations for travel/attendance.

Mobility Requirements:

- The patient is [completely immobile / able to walk short distances / unable to climb stairs].
- The patient requires a [manual/electric] wheelchair for all transit.
- [If applicable] The patient requires assistance with transferring from a wheelchair to a seat.
- [If applicable] The patient must remain in their own specialized wheelchair during transit.

Equipment Specifications:

- **Type:** [Manual / Power / Scooter]
- **Battery Type (if electric):** [Dry Cell / Lithium-Ion / Gel]
- **Dimensions:** [Height x Width x Length]
- **Weight:** [Weight in kg/lbs]

Medical Necessity:
The use of this mobility device is medically necessary for the patient's safety and independence. The patient is medically cleared to travel/participate, provided the aforementioned accommodations are met.

If you require further medical information or clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

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

[Clinic/Hospital Name]
[Address]
[Phone Number]