Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID: [Insert ID Number]

RE: POST-QUARANTINE INFECTIOUS DISEASE CLEARANCE

To Whom It May Concern,

This letter serves to certify that the above-named patient has completed the required quarantine period for [Insert Name of Disease/Condition].

The patient was placed under medical observation/isolation starting on [Start Date] and concluded the period on [End Date]. As of the final evaluation on [Current Date], the patient meets the following criteria for discharge:

- Completion of the mandatory isolation duration.
- Absence of fever for at least [Number] hours without the use of fever-reducing medication.
- Significant improvement in respiratory or systemic symptoms.
- [Optional] Negative laboratory test results obtained on [Insert Date].

Based on current clinical guidelines, the patient is no longer considered infectious and is cleared to resume normal activities, including return to work or school, effective [Date of Return].

Should you require further verification, please contact our office at [Insert Phone Number].

Sincerely,

[Signature]

[Physician Name, Degree]
[Medical Facility Name]
[License Number]