

Date: [Insert Date]

To Whom It May Concern,

This letter is to certify that **[Patient Full Name]** (Date of Birth: [DOB]) was under my medical care for a respiratory infectious disease starting on [Date].

As of [Date of Evaluation/Clearance], the patient has met the following clinical criteria for discharge and return to normal activities:

- The patient has been afebrile (fever-free) for at least 24 hours without the use of fever-reducing medication.
- Respiratory symptoms (such as cough or shortness of breath) have significantly improved.
- The patient has completed the recommended isolation period in accordance with current public health guidelines.

The patient is now considered non-contagious and is cleared to return to work, school, or daycare on **[Return Date]** without restrictions.

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

Sincerely,

[Signature]

[Physician Name, MD/DO]

[Clinic/Facility Name]

[Address]

[Phone Number]