[Date]

Dear [Patient Name],

Welcome to [Clinic/Program Name]. This letter confirms your enrollment in our Shift Work Sleep Disorder (SWSD) management program.

We understand that working non-traditional hours presents unique challenges to your sleep quality, safety, and overall well-being. Our goal is to provide you with the tools and strategies necessary to adjust your internal clock and improve your alertness during working hours.

As part of your program, you will receive:

- A personalized sleep and wake schedule.
- Guidance on light therapy and environmental adjustments.
- Strategies for managing caffeine and nutrition.
- Medical consultation regarding sleep aids or wake-promoting medications, if applicable.

Your first appointment is scheduled for:

Date: [Date]
Time: [Time]
Location: [Location/Virtual Link]

Please complete the enclosed sleep diary for the next seven days and bring it to your first visit. This data is essential for tailoring your treatment plan.

We look forward to helping you achieve better rest and better health.

Sincerely,

[Provider Name]
[Title]
[Clinic Name]
[Phone Number]