

Medical Fitness Certification

Date: [Insert Date]

To Whom It May Concern,

This is to certify that **[Patient's Full Name]**, born on **[Date of Birth]**, has undergone a comprehensive medical evaluation and is deemed fit to participate in rehabilitation programs.

After thorough assessment, which included physical examination and necessary tests, I confirm that the patient exhibits:

- Stable health condition
- Normal vital signs
- Ability to engage in moderate physical activities

The patient is recommended to join the rehabilitation program specific to their needs for optimal recovery and improvement.

Should you require any further information, please feel free to contact my office.

Sincerely,

[Physician's Name]

[Medical License Number]

[Clinic/Hospital Name]

[Contact Information]