



Medical Clearance Letter

Medical Office, please complete:	
Practitioner Name	
Role and License #	
Email / Contact #	
Date of Clearance Letter	
Practitioner / Patient please complete:	
Date of Concussion	
Date of Concussion Diagnosis	
Organization/Individual Requesting Medical Clearance	

To Whom It May Concern:

Patients with a concussion should be assessed and managed by a doctor, nurse practitioner, or licensed healthcare professional with relevant training. The goal of concussion management is to support the patient’s complete recovery from concussion by promoting a safe and gradual return to activity following a step-wise approach. For more detailed information and resources, please refer to the Concussion Awareness Training Tool (CATT) at cattonline.com.

As part of the strategy, this patient had previously been instructed to avoid all activities that could potentially place them at risk of another concussion or head injury until a medical clearance letter is provided (due to organizational requirements, dangerous job duties, contact sports, etc.). This patient has explained the organizational requirements and the duties/activities they participate in, and I have personally completed a medical clearance on this patient.

Name of Patient: _____

Note that the patient’s recovery is individual. Progression through the strategies may be slowed when there is more than a mild and brief symptom exacerbation.*

This patient can return with full participation to work, school, or physical activities **without restriction**.

This patient can return to work, school, or physical activities **with the following restriction(s)**:

Restriction(s) Physical & Cognitive	Details	Timeline

*Mild exacerbation (worsening) of symptoms: No more than a 2-point increase when compared with the pre-activity value on a 0-10-point symptom severity scale.**

**Brief exacerbation of symptoms: Worsening of symptoms for up to 1 hour.

**0-10 point symptom severity scale: Please see the [Visual Analog Scale](#) for an example of a 0-10 symptom severity scale.

This patient can return with full participation to work, school, or physical activities **without accommodation related to the concussion.**

This patient can return to work, school, or physical activities **with the following accommodation(s):**

Accommodation(s) Physical & Cognitive	Details	Timeline

Your understanding and support are critical components in this patient's continuing recovery.

Yours Sincerely,

Signature _____

Stamp 

It is recommended that this document be provided to the patient without charge.