CONCUSSION
Medical Clearance Letter

Name of patient

To be complete by the Medical Office

Name of the Medical Office	
M.D. / N.P. name[1]	
Medical License #	
Email / Contact #	
Date of Clearance Letter	

To be complete by M.D./N.P./Patient

Date of Concussion	
Date of Concussion Diagnosis	
Medical Clearance require by	

To Whom It May Concern:

Patients with a concussion should be assessed and managed by a medical professional. 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 staged 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.

Note that the patient's recovery is individual. After Stage 2, if new or worsening concussion symptoms are experienced the patient has been instructed to return to the previous stage of the strategy for 24 hours.

1. Depending upon physician or nurse practitioner access, the Medical Assessment Letter may be completed by a nurse with access to a licensed physician or nurse practitioner. Forms completed by other health care professionals (e.g., physiotherapists, chiropractors, and other allied health care professionals) should not be accepted. It is recommended that this document be provided to the patient without charge.

Name of patient

☐ This patient can return will **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***

☐ This patient can return will **FULL** participation to work, school or physical activities **WITHOUT ACCOMMODATION.**

☐ This patient can return to work, school, or physical activities **WITH THE FOLLOWING ACCOMMODATION(S).**

Accommodation(s) Physical & Cognitive	***Details***	***Timeline***

Signature: _____ M.D. / N.P. *(please circle appropriate designation [1])*

1. Depending upon physician or nurse practitioner access, the Medical Assessment Letter may be completed by a nurse with access to a licensed physician or nurse practitioner. Forms completed by other health care professionals (e.g., physiotherapists, chiropractors, and other allied health care professionals) should not be accepted. It is recommended that this document be provided to the patient without charge.