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DOCTOR NAME

Your Clinic Address

Your Clinic Phone No.

Doctor Qualifications

DOCTOR’S NOTE

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

I am writing to confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been diagnosed with a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. To facilitate a full recovery of the patient, his/her recommended rest period is from \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_. During this time, it is advised that he/she should refrain from attending work.

Your cooperation in helping to prevent the spread of illness is greatly appreciated.

Sincerely,

[Title/Position]
[Clinic Name]
[Contact Number]

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[Doctor's Sign]
[Title/Position]
[Clinic Name]
[Contact Number]