

**CONTACT NO.**

**CLINIC ADDRESS**

**CLINIC NAME**

**DOCTOR NAME**

Doctor Specialization

**DOCTOR’S NOTE**

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| Date: |  |  | Time: |  |

**TO WHOM IT MAY CONCERN**

Please excuse, Mr./Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FROM** |  | | | **DUE TO** | |  |
|  | | | |  | | |
| Work | | | | Injury | | |
| College/University | | | | Illness | | |
|  | |  |  |  |  | |
| Other: |  | |  | Other: |  | |

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| **EXCUSE PERIOD** | | | | |  | | | | | | | | | | | | | | | | | | | |
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| Restrictions or accommodations necessary upon return: |
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|  |  |  |
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|  |  |  |
| Date |  | Doctor Signature |

**DOCTOR’S NOTE**

DOCTOR NAME

Clinic Name

Clinic Address

Contact No.

|  |  |  |  |  |
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| Date: |  |  | Time: |  |

**TO WHOM IT MAY CONCERN**

Please excuse, Mr./Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FROM** |  | | | **DUE TO** | |  |
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| **EXCUSE PERIOD** | | | | |  | | | | | | | | | | | | | | | | | | | |
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| Restrictions or accommodations necessary upon return: |
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|  |  |  |
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