

**CONTACT NO.**

**CLINIC ADDRESS**

**CLINIC NAME**

**DOCTOR NAME**

Doctor Specialization

**DOCTOR’S NOTE**

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

**TO WHOM IT MAY CONCERN**

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

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

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| **EXCUSE PERIOD** |  |
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|  |  |
| From: |  |  | - |  |  | - |  |  |  |  |  | To: |  |  | - |  |  | - |  |  |  |  |

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| Restrictions or accommodations necessary upon return: |
|  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Date |  | Doctor Signature |

**DOCTOR’S NOTE**

DOCTOR NAME

Clinic Name

Clinic Address

Contact No.

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

**TO WHOM IT MAY CONCERN**

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

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| **FROM** |  | **DUE TO** |  |
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| [ ]  Other: |  |  | [ ]  Other: |  |

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