

**CLINIC NAME**

**DOCTOR’S NOTE**

To Whom It May Concern,

This letter is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ had an appointment on \_\_/\_\_/\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The patient was diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, which required medical attention and necessitated absence from work. As a result, the patient is excused from on-site work from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Special work-related restrictions (if any):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you have any further questions or require additional information regarding the patient's medical condition, treatment plan, or work accommodations, please do not hesitate to contact our office at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We are available to provide any further documentation or clarification needed to support the patient's health, recovery, and safe return to work.

Please feel free to reach out during our office hours, and we will be happy to assist.

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| --- | --- | --- |
|  |  |  |
| Physician Name |  | Physician Signature |
|  |  |  |
|  |  | Date |

Website

Contact Number

Clinic Address

**DOCTOR’S NOTE**

CLINIC NAME

Clinic Address

Clinic Phone No.

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|  |  |  |
| Physician Name |  | Physician Signature |
|  |  |  |
|  |  | Date |