

Hospital Address

Contact Number

**HOSPITAL NAME**

**DOCTOR’S MEDICAL NOTE**

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

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| --- | --- | --- | --- |
| **Patient Name:** |  | **Gender:** |  |
| **Age:** |  | **Occupation:** |  |
| **Blood Pressure:** |  | **Pulse Rate:** |  |

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| --- | --- |
| **Diagnosed with:** |  |
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|  |  |
| --- | --- |
| **Prescribed Medications:** |  |
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| --- | --- |
| **Instructions:** |  |
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| --- | --- | --- | --- |
| **Return to Work/Activity:** |  |  |  |

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

Hospital Website

Hospital Email

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| **Instructions:** |  |
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| --- | --- | --- |
|  |  |  |
| Doctor Name |  | Doctor Signature |
|  |  |  |
|  |  | Date |