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**HOSPITAL NAME**

123 Any Street, New York, USA

123-678-XXXX

hospital@email.com



|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Time: |  |
| Patient Name: |  | Age: |  |

**DOCTOR’S NOTE**

This is to certify that I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am providing medical care to the above-named patient

who has been evaluated and diagnosed with Influenza (Flu).

|  |
| --- |
| **Condition:** |
|  |
|  |

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| **ACTIVITY LIMITATIONS** |
| Based on the patient’s condition, the following limitations are advised: |
| [ ]  No strenuous physical activity | [ ]  Limited cognitive tasks due to fatigue |
| [ ]  Other: |  |  |

|  |
| --- |
| **PATIENT MAY RETURN TO SCHOOL/WORK** |
| [ ]  Today | [ ]  Tomorrow |
| [ ]  On |  | , |  | / |  | / |  |  |

|  |  |
| --- | --- |
|  |  |
|  | Doctor’s Signature |
|  |  |
|  | Date |

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|  |  |
| --- | --- |
|  |  |
| [Doctor’s Stamp] | Doctor’s Signature |
|  |  |
|  | Date |