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**DOCTOR NAME**

DOCTOR QUALIFICATIONS

CLINIC NAME

**DOCTOR’S NOTE**

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

This is to confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was examined by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the above date. The patient was diagnosed with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. He/she may return to the office or school on \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_ under the following physical/work restrictions (if any):

|  |
| --- |
| 123 Any Street, New York, USA123-678-XXXXclinic@email.com |

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

**DOCTOR’S NOTE**

**DOCTOR NAME**

Clinic Name

123 Any Street, New York, USA

123-678-XXXX

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

This is to confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was examined by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the above date. The patient was diagnosed with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. He/she may return to the office or school on \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_ under the following physical/work restrictions (if any):

|  |
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|  |

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