

**DOCTOR NAME**

**DOCTOR QUALIFICATIONS**

CLINIC NAME

**Doctor’s Excuse Note**

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| --- | --- | --- | --- | --- |
| Date: |  |  | Patient Name: |  |
| Age: |  |  | Gender: |  |

This is to confirm that the patient mentioned above was examined by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the above date. The patient was diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

He / She is fit / unfit to participate in sports or physical activities at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ until \_\_/\_\_/\_\_\_\_, with the following restrictions (if any):

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| **Recommendations for Return to Play (if applicable):** |
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|  |  |  |
| Date |  | Doctor Signature |

**Phone No.:** 123-678-XXXX

**Email:** clinic@email.com

**Address:** 123 Any Street, New York

**DOCTOR’S EXCUSE NOTE**

Clinic Address

Doctor Name

Doctor Qualifications

Phone Number

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| Date: |  |  | Patient Name: |  |
| Age: |  |  | Gender: |  |

This is to confirm that the patient mentioned above was examined by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the above date. The patient was diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

He / She is fit / unfit to participate in sports or physical activities at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ until \_\_/\_\_/\_\_\_\_, with the following restrictions (if any):

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| **Recommendations for Return to Play (if applicable):** |
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| --- | --- | --- |
|  |  |  |
| Date |  | Doctor Signature |