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**DOCTOR NAME**

Doctor Specialization

Clinic Contact No.

Clinic Address

**DOCTOR’S EXCUSE NOTE**

**Date:** \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_

To Whom It May Concern,

This is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_was evaluated in my office on \_\_/\_\_/\_\_\_\_ for a comprehensive medical assessment. Based on my evaluation and the patient's current medical condition, I have diagnosed the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Due to the nature of this diagnosis, it is my professional opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is not medically cleared to travel at this time. Travel poses a potential risk to the patient’s health and could aggravate their condition, leading to further complications. For this reason, I recommend that the patient should refrain from all forms of travel until \_\_\_\_\_\_\_\_\_\_\_\_ or until further notice.

Please do not hesitate to contact my office if you require any additional information or clarification regarding the patient's condition or the specific travel restrictions.

Thank you for your understanding and cooperation in this matter.

Sincerely,

[Doctor Full Name]

[Title/Position]

[Clinic Name]

**DOCTOR NAME**

Doctor Qualifications

Clinic Address Clinic Contact No.

**DOCTOR’S EXCUSE NOTE**

**Date:** \_\_\_\_\_\_/\_\_\_\_/\_\_\_\_

To Whom It May Concern,

This is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_was evaluated in my office on \_\_/\_\_/\_\_\_\_ for a comprehensive medical assessment. Based on my evaluation and the patient's current medical condition, I have diagnosed the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for your understanding and cooperation in this matter.

Sincerely,

[Doctor Sign] [Doctor Full Name]

[Title/Position]

[Clinic Name]