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**CLINIC NAME**

123 Any Street, New York, USA

123-678-XXXX

hospital@email.com

**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):

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

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**CLINIC NAME**

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123-678-XXXX

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