****

|  |
| --- |
| **DOCTOR NAME**Doctor QualificationsClinic Address |

**DOCTOR’S NOTE**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ provided medical care to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. It certifies that for medical reasons, this patient will not attend work, starting on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |
| --- |
| Given the health information before me (indicate all that apply): |
| [ ]  The patient may return to work with/without restrictions on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| [ ]  The patient needs further medical assessment before returning to work. |
|  |
| My opinion is based on the factors indicated below: |
|  |
|  |
|  |
|  |
| Date of next appointment is (indicate n/a if not applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |



Regards,

[Physician’s name]

**DOCTOR’S NOTE**

|  |
| --- |
| Doctor NameDoctor QualificationsClinic Address |

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ provided medical care to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. It certifies that for medical reasons, this patient will not attend work, starting on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |
| --- |
| Given the health information before me (indicate all that apply): |
| [ ]  The patient may return to work with/without restrictions on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| [ ]  The patient needs further medical assessment before returning to work. |
|  |
| My opinion is based on the factors indicated below: |
|  |
|  |
|  |
|  |
| Date of next appointment is (indicate n/a if not applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

Regards,

[Physician’s name] [Physician’s Sign]