**DOCTOR’S NOTE**

**[NAME] MEDICAL GROUP**

|  |  |
| --- | --- |
| **Add with solid fill** | **Medical Practitioner Information:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doctor’s Name: | **[Doctor's Full Name]** |  | Medical Credentials: | **[Medical Credentials]** |
| Clinic Name: | **[Clinic's Name]** | Address: | **[123 Health St.,]** |
| Phone Number: | **[000-00000]** | City: | **[Wellness City]** |
| Email Address: | **[Emailaddress@server.com]** | State: | **[ST 12345]** |
| Website: | **[www.website.com]** | Zip Code: | **[00000]** |

|  |  |
| --- | --- |
| **Add with solid fill** | **Patient Information:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  | Date of Birth: | \_\_/\_\_/\_\_\_\_ |

|  |  |
| --- | --- |
| **Add with solid fill** | **Dates of Absence:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Start Date: | \_\_/\_\_/\_\_\_\_ | End Date: | \_\_/\_\_/\_\_\_\_ |

**Due to:**

|  |
| --- |
| [ ]  Injury |
| [ ]  Illness |
| [ ]  Other (Specify):  |  |

I, the undersigned medical practitioner, certify that the information provided in this form is accurate and that the patient named above is temporarily unable to perform their job duties due to the mentioned medical condition. I recommend that the patient refrains from work until they have sufficiently recovered or until the specified end date, whichever comes first.

**Signature of Doctor**

|  |
| --- |
|  |

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