

Doctor's Note

Name of Medical Clinic: _____

Address:

Phone Number: _____

Patient's Records

Name: _____ Gender: _____

Age: _____ Date: _____

Dear _____

Please allow _____ (patient's name) from effective

_____ days, due to the following medical condition.

Illness and prescription

Attested By:

(Signature of the doctor)

Doctor's Note

Doctor's Name: _____

Date: _____

Please Excuse: _____

From: _____

Due To: _____

Regards,

(Authorized Signature)

Dr. _____

DOCTOR'S NOTE

Doctor's Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

[INSERT CLINIC LOGO]

Date: _____

Please Excuse: _____

From: (indicate check mark)

Work

School

Other

Due To:

Injury

Illness

Medical Appointment / Other

For the following dates:

from _____ to _____

Dr. _____

(Authorized Signature)

DOCTOR'S NOTE

Date: ____ / ____ / 20__

Reference No: _____

Practitioner Name _____

Patient Name:

Date of Birth: ____ / ____ / _____

The above-named patient was under my professional care and received a medical evaluation on ____ / ____ / 20__.

Following clinical assessment, it is my professional opinion that the patient is temporarily incapacitated due to medical reasons.

Accordingly, I have advised total absence from all workplace and academic obligations for a duration of ____ days, effective from ____ / ____ / 20__, with an anticipated return date of ____ / ____ / 20__.

Please afford the patient the necessary accommodations during this period of convalescence.

Sincerely,

Authorized Signature

[OFFICIAL CLINIC STAMP]

Medical License/Reg No: _____

Direct Clinic Line: _____

DOCTOR'S NOTE

Address Line 1: _____
Address Line 2: _____
Phone Number: _____ Email: _____

DATE: ____ / ____ / 20____
PATIENT'S NAME: _____
DATE OF BIRTH: ____ / ____ / _____

TO WHOM IT MAY CONCERN,

This is to certify that the patient named above was seen and examined by the undersigned medical professional on [**Date**] ____ / ____ / 20____.

Based on my medical evaluation, the patient is:

FIT to return to work / school on [**Date**] ____ / ____ / 20____.

UNFIT for work / school for a period of _____ days,
from [**Start Date**] ____ / ____ / 20____ to [**End Date**] ____ / ____ / 20____.

The patient may resume normal, unrestricted activities on [**Date**] ____ / ____ / 20____.

SIGNATURE & CREDENTIALS

DOCTOR'S SIGNATURE: _____ DATE SIGNED: ____/____/20____

DOCTOR'S NAME (Printed): _____

MEDICAL LICENSE NO.: _____

[PLACE CLINIC / HOSPITAL STAMP HERE]

COMMENTS / ADDITIONAL NOTES:

