

# Doctor's Note

Doctor's Name:

Medical Practice/Hospital Name:

Address:

Phone Number:

Email Address:

Date:

To Whom It May Concern,

This is to certify that \_\_\_\_\_ has been under my care and is currently being treated for \_\_\_\_\_. As a result, they are advised to \_\_\_\_\_ for a period of \_\_\_\_\_.

Please feel free to contact our office for any further information or clarification.

Sincerely,



Doctor's Name:

Medical License Number: