**Doctor’s Sick Note Template**

|  |
| --- |
| [Doctor’s Full Name][Doctor's Medical Registration Number][Doctor’s Contact Details]**Date:** [Date]**To:** [Recipient’s Full Name][Recipient's Position or Relation to Patient][Recipient's Contact Details]**Subject:** Medical Certification of IllnessDear [Recipient’s First Name],I am writing this letter to confirm that my patient, [Patient's Full Name], has been under my care since [Start Date of Treatment]. |
| Please find below the necessary medical details: |
| **Patient Information:** |
| **Full Name:** | [First Name][Last Name] |
| **Date of Birth:** | [MM/DD/YYYY] |
| **Gender:** | [Male/Female/Other] |
| **Contact Details:** | [Patient's Contact Information] |
| **Medical Insurance (If any):** | [Medical Insurance Details] |
| **Medical Condition:** |
| **Diagnosis:** | [Diagnosis of Illness/Injury] |
| **Description of Illness/Injury:** | [Detailed Description of Patient's Condition] |
| **Treatment Plan:** | [Proposed Treatment Plan, Including Medication, Therapies, Surgery, etc.] |
| **Start Date of Illness/Injury:** | [MM/DD/YYYY] |
| **Estimated Duration of Illness/Injury:** | [Estimated Recovery Time in Days/Weeks/Months] |
| **Medical Restrictions:** |
| **Work/School Restrictions:** | [Any Restrictions on Work/School Activities] |
| **Physical Activity Restrictions:** | [Any Restrictions on Physical Activities] |
| **Dietary Restrictions:** | [Any Restrictions or Changes to Diet] |
| In consideration of the above medical condition, it is necessary for [Patient's Full Name] to take a leave of absence from [work/school/other activities] starting from [Start Date of Leave] and expected to continue until [End Date of Leave].During this period, it is crucial for the patient to focus on recovery and follow the prescribed treatment plan. Regular check-ups and monitoring of the patient's condition have been scheduled and any changes will be communicated accordingly.I appreciate your understanding and cooperation in this matter. If you need any further information or clarification regarding this certification, please feel free to contact me at the provided details. |
| Your Sincerely,[Doctor’s Signature][Doctor’s Full Name][Doctor’s Designation] |