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| **Dr. Naila Brown, M.D.** | | | |
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|  | | | |
|  | | | **Date:** \_\_\_\_\_\_\_\_\_\_\_\_ |
| This is to confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was seen in my clinic / office on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | |
|  | | | |
|  | The patient may return to work / school on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | |
|  | The patient should work / study no more than: \_\_\_\_\_ house a day until \_\_\_\_\_\_\_\_\_\_\_. | | | |
|  | The patient can return to work / school with no limitation. | | | |
| **Instructions / Restrictions:** | | | |
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| **Sincerely,** | | | |
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| **Dr. Naila Brown, MD** | |  | |