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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,** |
|  |  |
| **Dr. Naila Brown, MD** |  |