**EYE DOCTOR EXCUSE NOTE**

| **DOCTOR’S INFORMATION:** |
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|  |
| **Doctor’s Name:** | [Full Name] |
| **Specialization:** | [Specialization] |
| **Clinic/Hospital Name:** | [Name] |
| **Office Address:** | [Complete Address] |
| **City, State, ZIP Code:** | [City, State, ZIP Code] |
| **Email Address:** | [email@highfile.com] |
| **Phone Number:** | [0000-000-000] |
|  |
| **PATIENT’S INFORMATION:** |
|  |
| **Patient’s Name:** | [Full Name] |
| **Patient’s Address:** | [Complete Address] |
| **City, State, ZIP Code:** | [City, State, ZIP Code] |
| **Date of Birth:** | [MM/DD/YYYY] |
|  |
| **APPOINTMENT DETAILS:** |
|  |
| **Date of Appointment:** | [MM/DD/YYYY] |
| **Time of Appointment:** | [Time] |
| **Reason of Appointment:** | **☐** Routine Eye Examination | **☐** Visual Activity Test |
| **☐** Cataract Evaluation | **☐** Retinal Examination | **☐** Glaucoma Screening |
| **☐** Other Eye Condition | [Details] |
|  |
| **MEDICAL NECESSITY FOR ABSENCE:** |
|  |
| **☐** Diagnostic Procedure | [Specify] |
| **☐** Surgical procedure | [Specify] |
| **☐** Post Procedure Recovery | [Specify] |
| **☐** Prescription Adjustment Period | [Specify] |
| **☐** Other | [Specify] |
| **Length of Recommended Rest Period:** | [Length] |
| **Excuse From:** | **☐** School | **☐** Work |
| **☐** Other | [Details] |
| **Special Recommendations (If any):** | [Details] |
|  |
| **DOCTOR’S VERIFICATION:** |
|  |
| I, [Full Name], confirm that the above information is accurate and that the patient requires rest and absence from duties as specified. |
| **Doctor’s Signature:** | [Signature] |
| **Date:** | [MM/DD/YYYY] |