**Doctors Note for Work Template**

[Your Clinic/Hospital Logo]

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Address Line 01:** | [Complete Address] | | |
| **Full Address Line 02:** | [Complete Address] | | |
| **City, State, ZIP Code:** | [City, State, ZIP Code] | | |
| **Phone Number:** | [0000-000-000] | | |
| **Website Link:** | [Link] | | |
| **Date:** | [MM/DD/YYYY] | | |
| **Patient Name:** | [First Name] [Last Name] | | |
| **Patient Address Line 01:** | [Complete Address] | | |
| **Patient Address Line 02:** | [Complete Address] | | |
| **City, State, ZIP Code:** | [City, State, ZIP Code] | | |
| **Subject:** Medical Excuse Note for [Purpose: e.g. Work, School] | | | |
| To Whom It May Concern,  I am writing to confirm that [Patient’s Full Name] was seen in my office on [Date of visit]. Please find the relevant details regarding the patient's medical condition and required absence or accommodations. | | | |
| **Patient Information:** | | | |
| **Full Name:** | [First Name] [Last Name] | | |
| **Date of Birth:** | [MM/DD/YYYY] | | |
| **Phone Number:** | [0000-000-000] | | |
| **Email Address:** | [email@highfile.com] | | |
| **Medical Condition:** | | | |
| **Diagnosis:** | [Diagnosis Details] | | |
| **Symptoms:** | [List of Symptoms] | | |
| **Treatment Plan:** | [Treatment Details] | | |
| **Medications Prescribed:** | [List of Medications] | | |
| **Period of Absence Required:** | | | |
| **Start Date:** | [MM/DD/YYYY] | | |
| **End Date:** | [MM/DD/YYYY] | | |
| **Total Days:** | [Number of Days] | | |
| **Work/School Restrictions or Accommodations:** | | | |
| **Restriction/Accommodation** | | **Description** | **Duration** |
| Limited Lifting | | Description | Time Period |
| Frequent Breaks | | Description | Time Period |
| **Special Considerations/Instructions:** | | | |
| [Detail any specific needs, instructions, or considerations the employer/school should be aware of.] | | | |
| **Attachments (If any):** | | | |
| [Provide information on any attached medical documents, x-rays, lab results, etc.] | | | |
| Please note that the information provided is confidential and should only be used for the intended purpose. If you have any questions or require further clarification, please do not hesitate to contact our office at [Clinic/Hospital Phone Number]. | | | |
| Sincerely, | | | |
| **Doctor Full Name:** | [First Name] [Last Name] | | |
| **Doctor Title:** | [Doctor Title] | | |
| **Medical License Number:** | [License Number] | | |
| **Signature (if submitting in hard copy):** | [Signature] | | |
| **Notice:** | | | |
| This note is provided as a professional courtesy and represents the medical opinion of the undersigned medical professional. The recipient is urged to consult legal counsel concerning any legal responsibilities with respect to the information provided herein. | | | |