|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Doctor's Sick Note for Flu** | | | | | | | | | | | | | | | |
| **Hospital Name:** | | |  | | | | | | | | | |  | | |
| **Address:** | | |  | | | | | | | | | |
| **City, Zip Code:** | | |  | | | | | | | | | |
| **Phone Number:** | | |  | | | | | | | | | |
| **Email / Website:** | | |  | | | | | | | | | |
| **Date:** | | |  | | | | | | | | | |
| **To whom it may concern,** | | | | | | | | | | | | | | | |
| This is to certify that: | | | | | (Patient’s Name) | | | | | | , born on | (Date of Birth) | | | , was |
| examined by me on | | | | (Examination Date) | | | | , and has been diagnosed with influenza (flu). | | | | | | | |
| **Recommended Rest Period:** | | | | | | | | | | | | | | | |
| From | (Start Date) | | | | | to | (End Date) | | | . | | | | | |
| It is advised that: | | (Patient’s Name) | | | | | | | abstain from work / school / other activities during | | | | | | |
| the specified period to ensure proper recovery and to prevent the spread of the flu to others. | | | | | | | | | | | | | | | |
| **Remarks / Additional Recommendations:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Doctor’s Name:** | |  | | | | | | | | | | | |  | |
| **Specialization:** | |  | | | | | | | | | | | |
| **License Number:** | |  | | | | | | | | | | | |
| **Signature:** | |  | | | | | | | | | | | |