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| **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:** |
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| **Doctor’s Name:** |  |  |
| **Specialization:** |  |
| **License Number:** |  |
| **Signature:** |  |