|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DOCTOR’S NOTE** | | | | | | | **Dr. Chris Mulkey, MD Dr. Joan Chen, MD** | | |
|  | | | | | | | | | |
| **City Care  Family Clinic** | | |  | | | | | | |
|  | | |  | | (555) 123-4567 | |
| 456 Wellness Ave,  Suite 75200, USA | | |  | | medcare@highfile.com | |
|  | | www.highfile.com | |
| To Whom It May Concern, | | | | | | | | | |
| This is to certify that: |  | | | , born on | |  | | | , was |
| examined by me on |  | | | , and has been diagnosed with Strep Throat. | | | | | |
|  | | | | | | | | | |
| **Recommended Rest Period:** | | | | | | | | | |
|  | | | | | | | | | |
| **Remarks / Additional Recommendation:** | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | |  | | |  | | | | |
| **Date** | | **Doctor’s Signature** | | | | |



|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DOCTOR’S NOTE** | | | | | | | | | | | |
|  | | | | | | | |  | | | |
| **Family Med Care Clinic** | | | | | | | | | |  | |
| Dr. Chris Mulkey , MD & Dr. Joan Chen, MD  456 Wellness Ave, Suite  75200, USA | | | | | | | | | | (555) 123-4567  medcare@highfile.com  www.highfile.com | |
| **Patient’s Information:** | | | | | | | | | | | |
| **Patient’s Name:** |  | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Gender:** |  | Male |  | | Female |  | **Patient’s Age:** | | | |  |
|  | | | | | | | | | | | |
| **Email Address:** |  | | | | |  | **Contact Number:** | | | |  |
|  | | | | | | | | | | | |
| **Date of Visit:** |  | | | | |  | **Date of Return to Work:** | | | |  |
|  | | | | | | | | | | | |
| To Whom It May Concern, | | | | | | | | | | | |
| The above-named patient was evaluated and diagnosed with strep throat. Due to the contagious nature of the illness and associated symptoms, they are advised to: | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | |  | | | | |  | | |
| **Date** | | | | **Doctor’s Signature** | | |

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