|  |  |
| --- | --- |
| **DOCTOR’S NOTE** | **Dr. Chris Mulkey, MDDr. 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, MD456 Wellness Ave, Suite 75200, USA | (555) 123-4567medcare@highfile.comwww.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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