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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Doctor’s Note Template for Work | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Doctor’s Full Name: | | | | | |  | | | | | | |
| Title / Position: | | | | | |  | | | | | | |
| Name of Medical Practice or Hospital: | | | | | |  | | | | | | |
| Address of Medical Practice or Hospital: | | | | | |  | | | | | | |
| City, State, ZIP: | | | | | |  | | | | | | |
| Phone Number: | | | | | |  | | | | | | |
| Fax Number (if applicable): | | | | | |  | | | | | | |
| Email Address (if applicable): | | | | | |  | | | | | | |
| Date: | | | | | |  | | | | | | |
| To whom it may concern, | | | | | | | | | | | | |
| I am writing to verify that my patient, | | | | | (Patient’s Full Name) | | | | | | | has been under my care for |
| (Duration of Care) | | | | . Due to their medical condition, they are unable to perform their usual work duties | | | | | | | | |
| effectively from | (Start Date) | | | | | | to | (End Date) | | . | | |
| **Medical Condition / Injury:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Work Limitations / Restrictions:** | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
| **Recommended Accommodations:** | | | | | | | | | | | | |
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| **Follow-Up Appointments:** | | | | | | | | | | | | |
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| **Additional Notes:** | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
| Physician’s Signature: | | |  | | | | | | | |  | |
| Full Name: | | |  | | | | | | | |
| License Number: | | |  | | | | | | | |
| Contact Information: | | |  | | | | | | | |  | |
| Please feel free to contact our office if you require any additional information or clarification.  Best Regards, | | | | | | | | | | | | |
| Doctor’s Name: | |  | | | | | | | | |  | |
| Title / Position: | |  | | | | | | | | |
| Contact Information: | |  | | | | | | | | |
| Clinic or Hospital’s Official Stamp (if applicable): | | | | | | | | |  | | | |