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| Doctor’s Note Template for Work |
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| 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:** |
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| **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): |  |