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| **Doctor's Excuse Note for Work**  |
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| **Doctor’s Full Name:** |  |  |
| **Medical License No.:** |  |
| **Hospital / Clinic Name:** |  |
| **Address:** |  |
| **City, State, Zip Code:** |  |
| **Phone Number:** |  |
| **Email:** |  |
| **Date:** |  |
| To whom it may concern, |
| I am writing to confirm that:  |   (Patient’s Full Name)  | was seen at our clinic / hospital on |
|  (Date of Visit)  | . Due to medical reasons, it is recommended that the said patient be excused from  |
| work for a duration of |   (Number of Days)  | , days, starting from |  (Start Date)  | to |
|  (End Date)  | . |
| **Reason for Absence:** |
|   |  |
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|   |
| **Additional Recommendations (if any):** |
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| It is crucial for: |   (Patient’s Full Name)  | ‘s health and recovery that these recommendations |
| are followed. If there are any concerns or if further clarification is needed, please feel free to contact the clinic/hospital at the number provided above.Thank you for your understanding and cooperation.Sincerely, |
| **Doctor’s Signature:** |  |  |
| **Doctor’s Full Name:** |  |
| **Specialization:** |  |
| **Date:** |  |