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| **Doctor's Excuse Note for Work** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **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:** | |  | | | | | | | |