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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Dr. Patric Brown, M.D.**  1234 Health Ave, New York, NY, USA **PH:** +1 111.234.5 **FX:** +1 111.234.5 www.highfile.com | **Date:** DD / MM / YY | | | | | | | | | |
| **Patient’s Name:** | |  | | | | **Date of Birth:** |  | |
|  | | | | | | | | |
| **First Day of Absence:** | | | | **Expected Return Date:** | | |  | **Total Days Absent:** |
|  | | |  |  | | |  |  |
|  | | | | | | | | |
| **Diagnosis / Reason for Absence:** | | | | | | | | |
|  | | | | | | | | |
| **Special Instructions / Recommendations (if any):** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Certification:** | | | | | | | | |
| I hereby certify that the above-named student is under my care and was found to be medically unfit for school attendance during the specified dates. | | | | | | | | |
| **Signature:** |  | | | |  | | | |