**Doctor’s Excuse Note Template**

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| [Doctor’s Full Name]  [Doctor’s Speciality]  [Doctor’s Address]  [City, State, ZIP Code]  [Phone Number]  [Fax Number]  [Email Address]  [Today’s Date]  To Whom It May Concern,  **Re:** [Patient’s Full Name]  **DOB:** [Patient’s Date of Birth]  I am writing this letter to verify that my patient, [Patient’s Full Name], was examined in my clinic. This letter serves to certify that they have been medically incapacitated and therefore unable to attend school/work due to the nature of their condition. | | |
| **Diagnosis Information:** | | |
| **Diagnosis** | **ICD-Code** | |
| [Diagnosis Name] | [International Classification of Diseases (ICD) Code] | |
| **Prognosis:** | | |
| **Start Date of Illness** | **End Date of Illness** | |
| [MM/DD/YYYY] | [MM/DD/YYYY] | |
| Please note that the prognosis is based on an estimate and is subject to change depending on the patient's progress and response to treatment. | | |
| **Treatment Plan:** | | |
| The patient is undergoing treatment which includes the following: | | |
| **Treatment/Medication** | **Frequency** | **Duration** |
| [Treatment/Medication Name] | [Frequency of the Treatment/Medication] | [Duration of the Treatment/Medication] |
| The patient is required to follow-up on [Follow-up Date] at our office to evaluate the progress and response to the treatment. Please note that this may affect the patient's ability to attend school/work until the date of recovery.  For privacy reasons, we cannot disclose all specific details of the patient's health condition. However, we can confirm that the patient's condition requires sufficient rest and rehabilitation before returning to regular activities. | | |
| **Medical Restrictions (If Any):** | | |
| The patient has been advised to restrict the following activities: | | |
| 1. [Activity Name] 2. [Activity Name] 3. [Activity Name] | | |
| **Accommodation Required (If Any)** | | |
| The following accommodations may be needed for the patient: | | |
| 1. [Accommodation Name] 2. [Accommodation Name] 3. [Accommodation Name] | | |
| **Additional Comments (If Any):** | | |
| [Additional doctor’s comments regarding the patient’s condition] | | |
| This medical excuse is given in good faith based on our professional assessment of the patient's health condition. Please contact us if further clarification is needed.  Thank you for your understanding and cooperation in this matter. | | |
| **Doctor Signature:** | [Signature] | |
| **Doctor Name:** | [First Name] [Last Name] | |
| **Doctor Medical License Number:** | [Doctor Medical License Number] | |
| **Date Signed:** | [MM/DD/YYYY] | |