[Doctor's Letterhead]
[Date]
[Recipient's Name]
[Recipient's Address]
[City, State, Zip Code]
Subject: Medical Certificate
To Whom It May Concern,
This is to certify that [Patient's Name], [Age], residing at [Patient's Address], has been under my care from [Start Date] to [End Date]. The patient was diagnosed with [Medical Condition] and required a period of [Duration] for treatment and recovery.
The patient is advised to refrain from [Activities/Work] during this period to facilitate recovery.
Should you require any further information, please do not hesitate to contact me.
Sincerely,
[Doctor's Name]
[Doctor's Qualifications]
[Medical License Number]
[Contact Information]