[Your Medical Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Recipient's Name]
[Recipient's Address]
[City, State, Zip Code]
Subject: Medical Certificate for Long-Term Illness
To Whom It May Concern,
I, Dr. [Your Name], a licensed physician, hereby certify that I have examined [Patient's Name], born on [Patient's Date of Birth], who has been under my care since [Date of First Appointment].
[Patient's Name] has been diagnosed with [specific illness or condition], which has resulted in significant limitations on their ability to perform daily activities and work-related tasks. The duration of this condition is expected to be [anticipated duration of illness, e.g., "long-term," "indefinite," etc.], requiring ongoing treatment and management.
It is my professional opinion that [he/she/they] will require a leave of absence from work and/or school effective [start date] until [expected return date].
Please feel free to contact my office should you require any further information or clarification regarding this medical condition.
Sincerely,
[Your Signature]
[Your Printed Name]
[Your Medical License Number]
[Your Specialty]
[Your Practice Name]