[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title/Position]
[Organization/Institution Name]
[Address]
[City, State, Zip Code]

Dear [Recipient's Name],

Subject: Medical Certificate

I, [Your Name], am a [Your Profession/Title], and I am writing to certify that [Patient's Name], [Patient's Age] years old, has been under my care from [Start Date] to [End Date].

During this time, [he/she/they] has been diagnosed with [Medical Condition] and is required to [mention any restrictions, if applicable, e.g., refrain from work, attend follow-up appointments, etc.].

[Patient's Name] is deemed unfit to carry out their regular activities from [Start Date] to [End Date] and may resume normal activities on [Expected Return Date].

Please feel free to contact my office at [Phone Number] or [Email Address] should you require any further information.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Medical License Number]
[Your Institution/Practice Name]