

[Your Clinic/Practice Name]

[Address]

[City, State, Zip Code]

[Phone Number]

[Email Address]

[Date]

To Whom It May Concern,

This is to certify that [Patient's Name], [Age], [Gender], was examined by me on [Date of Examination]. Due to [reason for absence, e.g., illness, surgery, etc.], it is my professional opinion that [he/she/they] was unable to attend work from [Start Date] to [End Date].

Patient's Condition: [Brief description of condition, if permissible under privacy laws]

The patient is advised to rest and may return to work on [Return Date].

Please do not hesitate to contact our office if you require additional information.

Sincerely,

[Doctor's Name]

[Medical License Number]

[Signature]