[Your Clinic's Letterhead]
[Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]

To Whom It May Concern,

This is to certify that I, Dr. [Your Full Name], am a licensed medical practitioner with [Your Qualifications] and [Your Experience Years] years of experience in the medical field. I have examined [Patient's Full Name] on [Date of Examination].

Based on my evaluation, I confirm that [Patient's Name] is medically fit/unfit to perform their job duties as [Job Title/Position] at [Company Name].

The details are as follows:

- Examination Date: [Date]
- Medical Condition: [Condition/Diagnosis]
- Recommendation: [Fit/Unfit for Work]
- Duration of Unfitness (if applicable): [Duration in Days/Weeks]

If you have any questions, please feel free to contact my office at [Phone Number].

Sincerely,
[Signature]
[Dr. Your Full Name]
[Medical License Number]
[Your Specialization]