[Your Medical Practice's Letterhead]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Recipient's Name]
[Recipient's Address]
[City, State, Zip Code]
Dear [Recipient's Name],
Subject: Medical Certificate
This is to certify that [Patient's Full Name], [Age], of [Patient's Address], has been under my care since [Start Date].
[He/She/They] has been diagnosed with [Medical Condition] and requires [specific treatment or rest] for a period of [duration].
[Optional additional information about the condition or treatment].
[Patient's Full Name] is advised to refrain from [specific activities] during this period to ensure full recovery.
Please do not hesitate to contact my office for any further information.
Sincerely,
[Your Name]
[Your Qualification]
[Your Medical License Number]
[Your Signature] (if sending a hard copy)
[Optional: Office Stamp]