[Your Clinic or Hospital Letterhead]
[Date]
[Patient's Name]
[Patient's Address]
[City, State, Zip Code]
[Patient's Date of Birth]

To Whom It May Concern,

This letter is to certify that [Patient's Name], born on [Patient's Date of Birth], underwent a PCR test for COVID-19 on [Test Date] at [Testing Facility Name]. The test results are as follows:

- **Test Result:** [Positive/Negative]
- **Test Type:** PCR (Polymerase Chain Reaction)
- **Test Sample Collection Method:** [e.g., Nasopharyngeal Swab]
- **Result Date:** [Result Date]

This document is issued for medical purposes. If you have any questions or require further information, please do not hesitate to contact our office at [Contact Number] or [Email Address].

Sincerely,
[Your Name]
[Your Title]
[Your Clinic or Hospital Name]
[Contact Information]
[License Number, if applicable]