

Dear:

Please Allow Mr./Mrs. From effective

days due to the following medical condition.

Illness and Prescription:

|  |
| --- |
|  |
|  |
|  |
|  |

Sincerely,

Signature of the Doctor

Date:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s Information | |  |  | |
|  | |  |  | |
| Name: |  |  | Age: |  |
| Gender: |  |  |  |  |

[Doctor Name]

[Clinic Address]

[Email]

[Phone Number]

Sample Doctor Note