

**Doctor's name:**

**Medical practice/Hospital name:**

**Address:**

**Phone number:**

**Email address:**

**Date:**

To whom it may concern,

This is to certify that \_\_\_\_\_ has been under my care and is currently being treated for \_\_\_\_\_. As a result, they are advised to \_\_\_\_\_ for a period of \_\_\_\_\_. Please feel free to contact our office for any further information or clarification.

Sincerely,

A handwritten signature in black ink, appearing to read "A. P." followed by a stylized name or initials.

**Doctor's name:**

**Medical license number:**