MEDICAL DOCTOR'S LETTER

Patient Name: _____ Date of Birth: _____

Doctor Information:

Full Name: _____

Medical License Number: _____

Specialty: _____

Office Address: _____

Phone/Email: _____

Letter Content:

To whom it may concern:

This letter is to certify that the above-named patient has been under my care. Based on my professional judgment and in accordance with applicable medical standards and United States law, I confirm the following medical information and recommendations:

1. Medical Diagnosis:

_____

_____

2. Treatment Summary:

_____

_____

3. Restrictions or Limitations:

_____

_____

4. Recommended Duration:

_____

5. Additional Remarks:

_____

_____

This letter is provided for the purpose of substantiating the medical condition of the patient and may be used accordingly under all applicable laws and regulations of the United States.

Doctor's Signature: _____

Date: _____

Medical Office Details:

Office Name: _____

Office Address: _____

Office Phone: _____

Office Email: _____

Doctor's Signature

Signature: _____

Patient's Acknowledgment

Signature: _____