MEDICAL INCAPACITY LETTER OF INCAPACITY

To Whom It May Concern:

This letter certifies that the undersigned medical professional has evaluated the patient identified below and determined that the patient is temporarily medically incapacitated and unable to perform work duties or other activities requiring physical or mental exertion as prescribed by a licensed practitioner.

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone / Email: _____

Medical Professional Information:

Name: _____

License Number: _____

Address: _____

Phone / Email: _____

Medical Evaluation Summary:

Based on clinical evaluation, tests, and observations, the patient suffers from a condition that temporarily prevents the safe and effective performance of work duties or other strenuous activities. The nature and severity of the condition require ongoing treatment and rest. Specific medical advice, restrictions, or accommodations should be followed strictly to promote recovery.

Medical Restrictions and Recommendations:

The patient is advised to refrain from the following activities during the period of incapacity:

- Performing heavy lifting or strenuous physical labor.
- Operating motor vehicles or machinery.
- Engaging in activities requiring sustained concentration or mental exertion.
- Other restrictions as noted by the medical professional.

Estimated Duration of Incapacity:

The medical incapacity period is estimated to last from: _____ to _____

Legal and Compliance Statement:

This letter is issued in accordance with applicable United States laws and regulations governing medical certifications and patient privacy. The information provided herein is confidential and intended solely for use by authorized parties. Unauthorized disclosure or use may be subject to legal penalties.

Acknowledgment and Signature:

I, the undersigned medical professional, certify that the information contained in this letter is accurate and based on my professional judgment and evaluation of the patient. This letter serves as formal documentation of the patient's temporary incapacity.

Medical Professional Signature **Patient Acknowledgment**

Signature: _____ Signature: _____

Medical Professional License Verification (if required):
