

# Medical Certification

Date: [Insert Date]

To Whom It May Concern,

I, Dr. [Physician's Name], am a licensed physician specializing in [Specialty]. This letter serves to confirm that I have been treating [Patient's Name] since [Date of First Visit] for [Medical Condition].

Due to [medical condition], it is my professional opinion that [Patient's Name] is unable to perform their usual work duties as of [Start Date of Disability].

Estimated duration of disability: [Duration]

Please feel free to contact my office at [Phone Number] for any further information.

Sincerely,

Dr. [Physician's Name]  
[Medical License Number]  
[Clinic/Hospital Name]  
[Address]  
[City, State, Zip Code]