Medical Certification

Patient's Name: [Patient Name]

Date of Birth: [Date of Birth]

Medical Record Number: [MRN]

Date: [Date]

To Whom It May Concern,

This letter serves as a medical certification for [Patient Name], who has been under my care since [Start Date]. After thorough evaluation and examination, I have determined that [he/she/they] has [medical condition] which may affect [his/her/their] capacity to [specific activities].

The estimated duration of this condition is [duration], and it may require [treatment or accommodations needed].

Please feel free to contact my office at [Phone Number] or [Email Address] for any further information or clarification regarding this matter.

Sincerely,

[Physician's Name]
[Professional Title]
[Medical Institution/Practice Name]
[Address]
[Phone Number]