**Doctor Note Template**



**Doctor's Name & Contact Information**

* **Name:** Dr. Jane Doe
* **Address:** 123 Health St, Wellness City, State, ZIP
* **Phone:** (123) 456-7890
* **Email:** drjane@healthclinic.com

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Information**

* **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Note**

**I have examined the above-named patient and confirm that they:**

* **Require medical leave from work/school due to their condition.**
* **Do not require medical leave but may need the following accommodations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recommended Period of Rest: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**