DOCTOR'S EXCUSE NOTE

Institution: _____

Dr. _____

Address: _____

Phone: _____

Email: _____

Date of examination: _____, 20_____

Return appointment: _____, 20_____

That is to certify that patient _____ was under my care at my office on _____, 20_____. Please excuse this absence.

Health issue description:

_____
_____
_____
_____
_____

EXAMINATION RESULT

☐ Full Duty: may return to work\school without any restrictions or limitations.

☐ Light Duty: may return to work\school with restrictions and\or limitations (described below). Restrictions duration: _____; Limitations duration: _____;

☐ Off Work: patient cannot return to work\school and is not able to perform their duties until _____, 20_____ or until next evaluation.

RESTRICTIONS (if applicable)

- ☐ No bending
- ☐ No twisting
- ☐ No lifting more than ____ lbs.
- ☐ No climbing

☐ Other:

_____
_____
_____

LIMITATIONS (if applicable)

☐ Working\Studying hours per day allowed: ____ hours.

☐ Must take at least ____ breaks during the working\studying day.

- ☐ Minimum break duration: ____ minutes.

☐ Must wear a brace

☐ Other:

_____
_____
_____

Additional Doctor's Comments:

_____
_____
_____
_____
_____

_____

(doctor's signature)