Dr. [Full Name]
[Office Address Line 1]
[Office Address Line 2]
Phone: [Office Phone Number]
Date: _____

To Whom It May Concern,

RE: Medical Leave Verification for [Patient Full Name]

I am the family physician for [Patient Full Name], who has been under my care since [Date/Year]. Due to medical reasons, it is necessary for [him/her/them] to be absent from work/school starting from _____ to _____.

This leave is recommended to support [his/her/their] recovery and ongoing treatment. Kindly accommodate this medical leave and allow [him/her/them] to return to normal activities upon my further notice or after the stated period.

If you require any additional information, please contact my office.

Sincerely,

_____
Dr. [Full Name]
[Medical License Number]