Medical Note

Dr. Graham Epic

[Address]

[City, State, Zip Code]

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Patient’s Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | Phone Number |  |
|  |  |  |  |
| Age |  | Email |  |

To whom it may concern,

The above mentioned patient was under my care on .

He/she will be able to return to work/school on .

Authorized by Dr. Raymond Leyham:

Signature