Sunshine Medical Clinic

Dr. Graham Epic, M.D.

[Address]

[City, State, Zip Code]

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**Patient’s Information:**

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

|  |  |
| --- | --- |
| This is to certify that: |  |
|  |  |
| was under my care on |  |

|  |  |
| --- | --- |
| and will be able to return to work on |  |

Authorized by Dr. Raymond Leyham:

Signature