Medical Status Confirmation Document

Date: _____

To Whom It May Concern,

This is to confirm that the patient named:

Full Name: _____

Date of Birth: _____

Patient ID / Record Number: _____

has been medically evaluated at our facility.

Current Medical Status:

_____

☐ Fit for work/school

☐ Unfit for work/school

☐ Requires further evaluation

☐ Other (please specify): _____

Additional Notes:

_____

Physician's Name: _____

Signature: _____

Date: _____
