

TREATING PHYSICIAN DECLARATION

Patient Information:

Name: [Patient Full Name]

Date of Birth: [MM/DD/YYYY]

Medical Record Number: [ID Number]

Physician Information:

Name: [Physician Full Name]

License Number: [License Number]

Specialty: [Medical Specialty]

Facility Name: [Clinic/Hospital Name]

Address: [Street Address, City, State, Zip Code]

Phone: [Phone Number]

Physician Declaration:

I, Dr. [Physician Last Name], am the treating physician for the patient named above. I have personally reviewed the patient's medical history and current physical condition. Based on my clinical evaluation and the medical records available, I declare the following:

1. **Diagnosis:** [List Primary Diagnosis and ICD-10 Codes]
2. **Date of Onset:** [MM/DD/YYYY]
3. **Treatment Plan:** [Brief Description of Treatment or Recommendations]
4. **Medical Necessity:** [State the necessity for specific leave, accommodations, or procedures]

I certify that the information provided in this declaration is true, accurate, and complete to the best of my professional knowledge and medical judgment.

Signature:

Physician Signature

Date: [MM/DD/YYYY]

[Official Medical Stamp/Seal]