

CLINIC NAME: [Insert Clinic Name]
ADDRESS: [Insert Clinic Address]
PHONE: [Insert Clinic Phone Number]
DATE: [Insert Date]

Medical Certificate of Recovery

To Whom It May Concern,

This letter is to certify that **[Patient Full Name]** (Date of Birth: [DOB]) was under my medical care for a diagnosed gastrointestinal infection, which commenced on [Start Date of Illness].

I have clinically evaluated the patient on [Date of Evaluation] and can confirm that they have completed the necessary treatment and have remained symptom-free for more than [Number] hours.

In accordance with standard health protocols, the patient is no longer considered contagious and is medically cleared to return to:

- Work / School
- Food handling duties (if applicable)
- General public activities

The patient is cleared to return to their full duties effective **[Return Date]**.

If you require any further information, please contact our office during business hours.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical License Number]
[Clinic Stamp]