[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To Whom It May Concern,

RE: Medical Certification for [Patient Name]
Date of Birth: [Patient Date of Birth]

This letter is to certify that [Patient Name] is currently under the medical care of [Doctor Name] at [Clinic Name]. The patient is being treated for a medical condition that requires the assistance and support of their family member, [Family Member Name].

Medical Summary:
[Briefly describe the nature of the illness or injury, e.g., recovery from surgery, chronic illness management, or acute medical event].

Necessity of Care:
Due to the patient's condition, they require assistance with [list requirements, e.g., basic medical needs, safety, transportation to appointments, or activities of daily living].

Duration:
It is estimated that the patient will require this level of care from [Start Date] through [Estimated End Date]. We recommend that [Family Member Name] be granted leave or certification to provide the necessary support during this period.

Should you require any further information or clarification, please do not hesitate to contact our office.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical License Number]