DATE: [Insert Date]

TO: [Insert Commanding Officer Name/Rank or Employer Name]
FROM: [Insert Name of Medical Provider/Clinic Director]
SUBJECT: Certification of Serious Illness and Rehabilitation Clinic Admission

PATIENT NAME: [Insert Servicemember Name]
RANK/RATE: [Insert Rank/Rate]
DOD ID NUMBER: [Insert ID Number]

This letter serves as official medical certification that the above-named Servicemember is currently under my professional care for a serious health condition. As part of the required clinical treatment plan, the Servicemember has been admitted to [Insert Name of Rehabilitation Clinic/Facility].

Clinical Details:

- **Admission Date:** [Insert Date]
- **Estimated Duration of Treatment:** [Insert Number of Days/Weeks]
- **Expected Discharge Date:** [Insert Date, if known]
- **Nature of Treatment:** Intensive inpatient/outpatient rehabilitation for a serious illness/injury incurred in the line of duty (if applicable).

Due to the intensive nature of this rehabilitation program, the Servicemember is currently unable to perform their military duties. Full participation in the clinical program is essential for the Servicemember's recovery and eventual return to duty status.

Care Provider Contact Information:

Facility Name: [Insert Facility Name]
Address: [Insert Address]
Phone Number: [Insert Phone Number]
Email: [Insert Email]

Please contact our office directly if you require further verification or updates regarding the Servicemember's status, subject to applicable privacy regulations (HIPAA).

Respectfully,

[Signature]
[Printed Name and Title]
[Medical License Number]
[Clinic/Hospital Stamp]