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

[Date]

To Whom It May Concern,

Subject: Medical Certification for Pregnancy-Related Leave

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

I am the treating physician for [Patient Name], who is currently under my care for a high-risk pregnancy. Due to the medical complications associated with this pregnancy, it is my professional recommendation that the patient take a formal leave of absence from work to ensure the safety and health of both the mother and the fetus.

The patient's medical condition necessitates the following restrictions and leave period:

- **Start Date of Leave:** [Start Date]
- **Estimated End Date of Leave:** [Estimated Return Date or "Pending Postpartum Recovery"]
- **Specific Restrictions:** [e.g., Strict bed rest, no lifting, no standing for long periods]

During this time, the patient is unable to perform the essential functions of their job. I will continue to monitor the patient's condition and will provide updates regarding any changes to their medical status or return-to-work date.

If you require any further information, please contact my office directly.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]