

MEDICAL CERTIFICATION FOR POSTPARTUM RECOVERY LEAVE

Date: [Date]

To: [Employer Name/Human Resources Department]

Company: [Company Name]

Address: [Company Address]

Patient Name: [Employee Full Name]

Date of Birth: [Employee Date of Birth]

To Whom It May Concern,

I am the healthcare provider for [Employee Name]. This letter serves as medical certification for their postpartum recovery leave following childbirth.

Date of Delivery: [Date]

Based on the clinical assessment of the patient's physical and medical condition following delivery, I am recommending a period of recovery during which the patient will be unable to perform their regular work duties. This period is necessary for physical healing and postpartum medical management.

Leave Start Date: [Start Date]

Estimated Return to Work Date: [End Date/Return Date]

The patient is expected to be under my care during this time. I will re-evaluate their condition prior to the return date to determine if any work restrictions or accommodations are required upon their transition back to the workplace.

Please feel free to contact my office if you require any further clarification regarding this medical certification.

Sincerely,

[Physician/Provider Signature]

[Physician/Provider Name, Title]

[Medical Facility Name]

[Phone Number]

[License Number]