

## MEDICAL CERTIFICATION OF DISABILITY

**Date:** [Date]

**To:** [Recipient Name/Employer/HR Department]

**Organization:** [Company Name]

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Date of Birth]

**Date of Procedure:** [Date of C-Section]

To Whom It May Concern,

I am the attending physician for [Patient Name]. This letter serves to certify that the patient underwent a Cesarean Section (C-Section) surgical procedure on [Date of Procedure].

Due to the nature of this major abdominal surgery, the patient requires a formal recovery period. During this time, the patient is restricted from performing work duties to ensure proper healing and to prevent complications such as incision dehiscence or infection.

### Medical Recommendations:

- The patient is excused from all work duties from [Start Date] through [End Date].
- Expected return to work date: [Date].
- Upon return, the patient must follow these restrictions for [Number] weeks:
  - No lifting objects heavier than 10-15 pounds.
  - Limited climbing of stairs.
  - No prolonged standing or strenuous physical activity.

The patient will be re-evaluated at their postpartum follow-up appointment on [Date] to determine if further extensions or modifications are necessary.

Should you require any further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]

[Clinic/Hospital Name]

[Address]

[Phone/Email]