[Date]

To: [Employer Name/Human Resources Department]
From: [Pediatrician Name/Medical Office]
Subject: Confirmation of Medical Necessity for Infant Bonding Time

To Whom It May Concern,

I am writing to confirm that **[Parent Name]** is the primary caregiver for **[Infant Name]**, born on **[Date of Birth]**. This patient is currently under my pediatric care.

Medical guidelines and pediatric health standards emphasize that a continuous period of bonding between a parent and an infant is essential for the child's physical and emotional development. This period is critical for establishing feeding routines, monitoring developmental milestones, and ensuring the infant's overall health and well-being.

I recommend that **[Parent Name]** be granted leave for infant bonding from **[Start Date]** to **[End Date]**. This time is necessary to support the health of the infant and the family unit.

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

Sincerely,

[Signature]
[Pediatrician Name, MD/DO]
[Medical Practice Name]
[License Number]