

**Date:** [Insert Date]

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

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

**Patient ID/Account Number:** [Insert ID Number]

**Subject: Physician Continuing Treatment and Condition Certification**

To Whom It May Concern,

I am writing to certify that [Patient Name] is currently under my professional care for the treatment of the following medical condition(s):

[Insert Diagnosis/Condition Name]

**Current Treatment Plan:**

The patient is undergoing a continuous course of treatment which includes: [Insert Treatment Details, e.g., medication, physical therapy, regular monitoring].

**Frequency of Visits:**

The patient is required to be seen in this office every [Number] weeks/months for evaluation and management of their condition.

**Clinical Status:**

At this time, it is my clinical opinion that the patient's condition is [Stable / Improving / Chronic] and requires ongoing medical intervention to prevent deterioration or complications.

**Estimated Duration:**

It is anticipated that this course of treatment will need to continue until approximately [Insert Date] or [Indefinitely].

**Work/Activity Limitations (if applicable):**

[Insert any specific restrictions or "No restrictions at this time"]

Should you require any additional information or further clarification regarding this patient's medical status, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[Medical License Number]

[Clinic/Hospital Name]

[Address]

[Phone Number]