

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

Date: [Current Date]

To Whom It May Concern,

This letter serves to certify the ongoing health status of **[Patient Full Name]**, Date of Birth: **[DOB]**, who is currently under my medical care.

The patient has been diagnosed with the following ongoing medical condition(s):

- [Condition 1]
- [Condition 2]

The patient is currently following a prescribed treatment plan which includes:

[Brief description of treatment, medications, or therapy]

At this time, the patient's condition is considered [Stable / Improving / Under Observation]. Due to the nature of this health status, the patient requires the following accommodations or restrictions:

[List specific accommodations or "No specific restrictions at this time"]

The next scheduled evaluation for this condition is on [Date]. This certification is valid until [Expiration Date or "Further Notice"].

Should you require any additional information or clarification, please contact our office directly.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical License Number]
[Clinic Name]