Date: [Date]

To: [Recipient Name/HR Department]
Company: [Company Name]
Address: [Company Address]

RE: Medical Leave of Absence for [Patient Name]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am the treating physician for [Patient Name]. This letter serves to formally certify that [Patient Name] is under my professional care for a medical condition that requires a temporary leave of absence from work for mental health recovery.

In my clinical opinion, the patient is currently unable to perform their essential job duties. I have recommended a period of continuous leave beginning on **[Start Date]**. At this time, it is anticipated that the patient will be able to return to work on **[Estimated Return Date]**.

During this period, the patient will be undergoing a structured treatment plan. I will reassess the patient's condition prior to the return date and provide further documentation if an extension of leave or workplace accommodations are necessary.

If you require any further information regarding the duration of this leave, please contact my office directly at [Phone Number]. Thank you for your cooperation in supporting the patient's recovery.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[License Number]
[Clinic/Hospital Name]
[Contact Information]