Date: [Insert Date]

To: [Recipient Name/Employer/Insurance Provider]
Organization: [Company Name]
Address: [Street Address, City, State, Zip Code]

RE: Medical Disability and Mandatory Quarantine for [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I am writing to formally certify that [Patient Name] is under my medical care. Due to a confirmed or suspected exposure to a communicable infectious disease, [Patient Name] is required to observe a mandatory period of quarantine and isolation.

Details of Disability Period:

- **Start Date:** [Start Date]
- **Estimated End Date:** [End Date]

During this timeframe, the patient is medically restricted from reporting to a physical workplace or public settings to prevent the transmission of illness. They are currently unable to perform their regular job duties due to health status and the legal/medical requirements of quarantine.

The patient will be re-evaluated on [Follow-up Date] to determine if it is safe to return to work. I request that you excuse their absence and provide any applicable short-term disability benefits or sick leave coverage as per your policy.

If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Doctor Signature]

[Doctor Name, Title]
[Medical Facility Name]
[License Number]