[Doctor's Name/Medical Practice Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Recipient Name/Employer Name/Insurance Provider]
Regarding: Medical Certification for [Patient Name]
Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am writing to provide initial medical certification for my patient, [Patient Name].

The patient is currently under my professional care for a documented medical condition. Based on my clinical evaluation on [Date of Examination], I have determined that the patient's condition began on or about [Onset Date].

At this time, the following medical facts apply to the patient's status:

- **Duration:** The condition is expected to last from [Start Date] until approximately [Estimated End Date].
- **Capacity:** The patient is [unable/partially able] to perform their regular duties due to the following limitations: [List brief restrictions or "Total incapacity for work"].
- **Treatment Plan:** The patient is currently undergoing [Treatment/Observation] and is scheduled for a follow-up evaluation on [Follow-up Date].

I certify that the information provided above is true and accurate based on the clinical evidence available. Should you require further clarification regarding this certification, please contact my office directly.

Sincerely,

[Signature]

[Doctor's Full Name, Degree]
[License Number/NPI]
[Medical Specialty]