POSTPARTUM RECOVERY CERTIFICATION

Date: [Date of Issue]

To Whom It May Concern,

This letter serves to certify that **[Patient Full Name]** (Date of Birth: [DOB]) was under my medical care for pregnancy and delivery.

Delivery Date: [Date]

Type of Delivery: [Vaginal / Cesarean Section]

The patient is currently in the postpartum recovery period. Based on my medical assessment, I am recommending the following:

- **Recovery Period:** The patient requires a recovery period from [Start Date] to [Estimated End Date].
- **Work Status:** [The patient is unable to work / The patient may return to work with the following restrictions].
- **Physical Restrictions:** [e.g., No lifting over 10 lbs, no strenuous activity, frequent rest breaks].

The patient is scheduled for a follow-up evaluation on [Date]. At that time, their ability to return to full duties will be re-evaluated.

Should you require any further information, please contact my office at [Phone Number].

Sincerely,

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