Date: [Insert Date]

To: [Employer Name/Human Resources Department]
From: [Physician Name/Medical Facility]
Subject: Medical Certification for Family Caregiver Leave

Patient Name: [Patient Full Name]
Patient Date of Birth: [Date of Birth]
Caregiver Name: [Employee Full Name]
Relationship to Patient: [e.g., Son, Daughter, Spouse]

To Whom It May Concern,

I am the attending physician for the patient named above. The patient is currently under my care for geriatric medical conditions that require consistent assistance and supervision.

Due to the patient's health status, it is medically necessary for [Employee Full Name] to provide care and assistance. This care includes, but is not limited to, assistance with basic medical needs, hygiene, safety monitoring, and transportation to medical appointments.

Estimated Duration of Leave:
The patient will require care beginning on [Start Date] and is expected to continue until [End Date or "Indefinitely"].

Frequency of Care:
[ ] Full-time continuous leave
[ ] Intermittent leave (approximately [Number] days per month)

Please contact my office at [Phone Number] if you require further verification regarding this medical necessity.

Sincerely,

[Signature of Physician]

[Printed Name of Physician]
[Medical License Number]
[Name of Medical Practice/Clinic]