MEDICAL CERTIFICATION FOR CAREGIVER LEAVE

Date: [Insert Date]

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

RE: Medical Certification for [Employee Name]

Dear [Recipient Name or Human Resources],

I am the healthcare provider for **[Patient Name]**, who has sustained an acute injury. **[Employee Name]** is the designated caregiver for the patient.

Patient Condition:
The patient is currently suffering from an acute injury involving [Brief description of injury, e.g., bone fracture, post-surgical recovery, trauma]. This condition requires active assistance and supervision.

Necessity of Care:
Due to the nature of this injury, the patient requires the employee's assistance for:

- Basic medical and hygienic needs.
- Transportation to medical appointments and physical therapy.
- Medication management and monitoring of vital signs.
- Assistance with mobility and safety.

Duration of Leave:
The patient's condition began on [Start Date]. It is my professional medical opinion that the employee will require leave to provide care from [Start Date] through [Estimated End Date].

Schedule:
The care required is [Continuous / Intermittent]. (If intermittent, please specify frequency: [Frequency]).

If you require further information regarding this certification, please contact my office at [Phone Number].

Sincerely,

[Doctor/Provider Signature]
[Printed Name and Title]
[Medical Facility Name]
[License Number]