Work/School
Medical Excuse

Date: _____

To Whom It May Concern:

Please be advised that _____ was seen in my office on _____/_____/_____.

Diagnosis:

_____

_____

_____.

_____ is able to return to work/school on: _____/_____/_____.

Restrictions/Limitations:

_____

_____

_____.

If you have any questions regarding this patient please do not hesitate to contact my office.

_____
Doctors Signature

The American College of Foot & Ankle Orthopedics & Medicine