

# DOCTOR LETTER OF INCAPACITY

Patient Name: \_\_\_\_\_ Patient ID Number: \_\_\_\_\_

Doctor Name: \_\_\_\_\_ License Number: \_\_\_\_\_

**Medical Certification:**

I hereby certify that I have examined the patient named above and that, in my professional medical opinion, the patient is currently incapacitated due to medical reasons and is unable to perform their normal work duties or daily activities. This incapacity is the result of an illness, injury, or medical condition that has been diagnosed and documented by me.

**Medical Diagnosis and Details:**

Diagnosis (ICD-10 Code if applicable):

\_\_\_\_\_  
\_\_\_\_\_

Summary of Medical Condition and Limitations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommended Period of Incapacity and Medical Restrictions:**

The patient is unable to perform work or usual activities from: \_\_\_\_\_ to:

\_\_\_\_\_ (dates to be filled by authorized personnel). Please provide any necessary

accommodations, limitations, or restrictions below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician's Statement and Legal Compliance:**

This letter is provided in compliance with applicable United States federal and state laws regarding patient privacy and medical certification. It is intended solely for the use of the patient and the designated recipient(s) and should be treated

as confidential medical information. Unauthorized disclosure or use of this letter without patient consent may be subject to legal penalties.

**Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician Contact Information:** \_\_\_\_\_

**PHYSICIAN'S SIGNATURE**

**PATIENT'S ACKNOWLEDGEMENT**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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