**MEDICAL REPORT**

**Patient Name:** [Your Name]  
**Date of Birth:** [Your DOB]  
**Date of Examination:** [Examination Date]  
**Medical Facility:** [Hospital/Clinic Name]  
**Doctor’s Name:** [Doctor’s Name]

**Diagnosis:**  
[Briefly describe the illness or condition, e.g., "Acute Respiratory Infection," "Migraine," "Back Pain," etc.]

**Medical Recommendation:**  
This is to certify that the above-named patient has been examined and diagnosed with [condition]. As a result, it is advised that they refrain from work/school/other activities from **[Start Date]** to **[End Date]** for proper rest and recovery.

**Additional Notes (if applicable):**

* [Optional: Any restrictions, medications prescribed, or follow-up instructions.]

**Doctor's Signature & Stamp**  
[Signature]  
[Doctor’s Contact Information]