## **DOCTOR’S NOTE FOR DEPRESSION/ANXIETY**

**MEDICAL CERTIFICATE**

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| **Date:** |
| **Time:** |
| **Patient Name:** |
| **Patient Age:** |
| **Patient Gender:** |
| **Patient Address:** |
|  |
| **Medical facility:** |
| **Title:** |
| **Physician:** |

This letter is a confirmation that **[patients name]** is suffering from anxiety/ depression. I recommend two weeks rest for healing. Please contact me if you need any clarification.

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| **Doctor’s Name:** |
| **Doctor’s Signature:** |