Center For
WOMEN'S HEALTH
& WELLNESS

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Excuse Note

Date: _____/_____/_____
Patient Name: _____
Date Of Birth: _____/_____/_____

This is to certify that the above name is/was a patient under my:

⬜ Obstetrical Care ⬜ Gynecological Care

⬜ The patient was seen in the office today.
⬜ The patient is approximately _____ weeks pregnant and her EDD is_____
⬜ The patient is able to work with no restrictions.
⬜ The patient is able to work with restrictions: _____
⬜ The patient is unable to work until: _____
⬜ The patient was not/is not able to report to work from: _____
⬜ The patient has had her post partum examination.
⬜ The patient has had her post operative examination.
⬜ The patient is scheduled to have surgery _____
⬜ The patient is able to return back to school with no restriction.
⬜ The patient is able to return back to school with restriction _____
⬜ The patient may have dental treatment including X-Ray with use of a lead apron for protection, Novocaine for local anesthetic, and Penicillin/Ampicillin as an antibiotic if there is no history of allergies.
⬜ Other

Sincerely,

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