

Date (day/month/year)

To Whom It May Concern

Name: (薬が必要な患者さんの名前)

Date of birth: (患者さんの誕生日)

Address: (患者さんの住所)

The individual named above is a patient of mine.

This person has been diagnosed with the medical condition(s) that requires treatment with the medication listed below.

- ・ (薬のリスト -名前、用量、用法 例：Aspirin 100mg once daily)
- ・
- ・
- ・
- ・

This person's family member, (薬を患者さんのために持ち込む家族の名前 例：Mr. Taro YAMADA) is bringing in these medications for (患者さんの名前) who is currently staying in New Zealand.

I appreciate your understanding.

For further information, please feel free to contact me.

Kind regards,

physician's signature :(医師の署名)

physician's name : (医師の名前 アルファベットで)

Address: (クリニックの住所、電話番号、メールアドレス等)

(クリニックのスタンプ)

Date:

To Whom It May Concern

Name:

Date of birth:

Address:

The individual named above is a patient of mine.

This person has been diagnosed with the medical condition(s) that requires treatment with the medication listed below.

-
-
-
-
-

This person's family member, _____ is bringing in these medications
for _____ who is currently staying in New Zealand.

I appreciate your understanding.

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Kind regards,

physician's signature :

physician's name :

Address: