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）

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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.

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I appreciate your understanding.

For further information please feel free to contact me.

Kind regards,

physician’s signature:

physician’s name:

Address: