# Doctor's Certificate for Eye Pain Leave

[Medical Professional's Letterhead]
[Doctor's Name]
[Medical Practice or Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]

To Whom It May Concern,

This is to certify that [Patient's Full Name], [Date of Birth], has been under my care for severe eye pain. After a thorough examination, it is advised that [he/she] take medical leave for a period of [number of days] starting from [start date] to [end date].

[Patient's Full Name] is required to refrain from work/school activities during this time to ensure proper rest and recovery.

If you require further information or clarification, feel free to contact me at the provided contact details.

Sincerely,

[Doctor's Name]
[Doctor's Designation]
[Medical License Number]
[Signature]