



The GW Medical
Faculty Associates

The GW Medical Faculty Associates
2150 Pennsylvania Ave NW
Washington, DC 20037

Date: _____

Patient Name: _____

To Whom It May Concern,

The person named above has been seen by our practice on this date and will not be able to work where they are in close contact with others for at least the next _____ calendar days. Thank you.

Healthcare Provider Signature

Healthcare Provider Name & Credentials (PRINTED)