HOJA MEMBRETADA
(NOMBRE Y DATOS DEL CONSULTORIO)

SELLO
STAMP

LETTERHEAD PAPER
(DOCTOR'S NAME, ADRESS
PHONE, E-MAIL)

FECHA (DATE)

To Whom It May Concern: DOB:_____

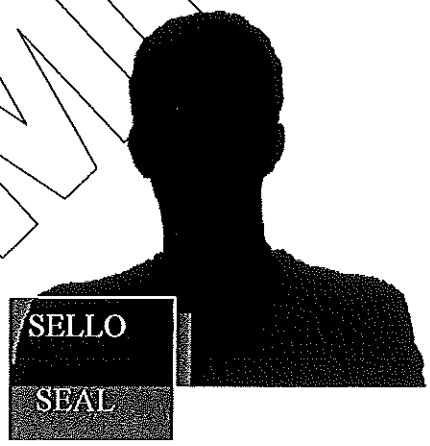
This is to certify that **Nombre completo (Full name),** son of **Nombre del Padre (Fhater Name),** and **Nombre de la Madre (Mother Name),** has been under my pediatric care since **Fecha (Date).**

(He or She) is in **"comentarios opcional (optional comments)".**

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

FOTO (PHOTO)



Nombre del doctor/a (Doctor's name)