

## PHYSICAL THERAPY

PHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

## WORK/SCHOOL NOTE

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

This patient has been treated at our clinic on the following times:

|           |               |
|-----------|---------------|
| Monday    | _____ - _____ |
| Tuesday   | _____ - _____ |
| Wednesday | _____ - _____ |
| Thursday  | _____ - _____ |
| Friday    | _____ - _____ |

If you have any questions, please feel free to contact us.

Therapist Signature: \_\_\_\_\_