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| **DR. NAME OF DOCTOR**  **General Medicine**  **UNIVERSIDAD AUTÓNOMA DE OAXACA**  Email: [doctoremail@gmail.com](mailto:doctoremail@gmail.com) **PROFESSIONAL ID : 12345678** WhatsApp : 123456789  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  WGT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  T/A: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DX:  I, the one who subscribes, a general doctor who is legally authorized to practice the profession, hereby allow myself to inform you that **Mr. RELATIVES NAME** has been a patient for 20 years. She is 88 years old. She has: diagnostic of a Cerebral Vascular Event from 2 years ago, which left a permanent aftermath like the capacity to care for herself. She also suffers from Parkinson's disease in a very advanced stage and advanced senile dementia. Due to all these pathologies and her old age, she is needing the assistance of her granddaughter GLENNIS Y HOFFMANN who lives out of Mexico and who she has not seen in years. In these difficult moments of his illness, her granddaughter's assistance would be very beneficial for her health and emotional support.  Hereby at the request of the interested party for the appropriate purposes.  DR. NAME OF DOCTOR PROFESSIONAL ID : 12345678  (signature as shown)  Address: Colonia Uno San Martin, SALINA CRUZ OAXACA, MEXICO  C.P. 123456 Pharmacy Phone Number: 123456789 |
| **TRANSLATION CERTIFICATION:**  I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that I am fluent in the English and Spanish languages, that I am competent to perform the translation, and that the above translation is the complete and accurate translation of the document entitled Doctor’s Letter pertaining to  **NAME OF RELATIVE** medical condition as described by **Dr. NAME OF DOCTOR.**  Your Full Legal Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ |