Letter of Medical Necessity - Prenatal Yoga

Patient's Name:_____

Patient's Date of Birth:_____

Patient's Social Security Number: _____

To Whom it May Concern,

I am the care provider for _____(patient's name). I approve _____(patient) to take Prenatal Yoga to maintain a healthy pregnancy. The duration of the Prenatal Yoga Classes is _____ to _____. Her due date is _____.

Any necessary additional information about her pregnancy is provided below:

_____

_____

_____

_____

_____

Sincerely,

_____(Care Provider's Name)

_____(Care Provider's Signature)

Care Provider's Title: _____

Care Provider's License Number and State:_____

Care Provider's Phone Number:_____