_____ CLINIC SLEEP CENTER
住所（英文）
電話／FAX／メールなどの連絡先

日付:

To Whom It May Concern:

Certificate of Medical Treatment and Request for Assistance

The bearer of this letter, _____(患者さんの名前(英文)), is one of my patients with obstructive sleep apnea syndrome. I have prescribed continuous positive airway pressure (CPAP) therapy for him using the device named CPAP_____ _____(装置の名称) (manufactured by 製造元の名称, distributed by _____ (国内販売元 in Japan, value of _____JPY)), which he carries with him/her to utilize nightly. The device is not his/her personal property nor for commercial purpose. It belongs to _____(処方した医療機関の名称（英文）) and currently rented to him/her under Japanese public medical insurance system in order to treat his/her disease.
I cordially ask for your kind assistance and arrangement to help him/her manage the therapy duly.

Thank you.
Best regards,,

処方した医師のサイン

処方した医師の名前（英文）,MD

医師の役職（英文）

医療機関名（英文）