

## Medical Certificate



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### Patient Information

- **Name:** {{patient\_firstname}} {{patient\_surname}}
- **Patient ID:** {{patient\_ID}}
- **Date of Birth:** {{birthday}}
- **Date of Certificate:** {{today}}

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To Whom It May Concern,

I hereby certify that {{patient\_firstname}} {{patient\_surname}} underwent a Total Hip Replacement on {{surgery\_date}}. The patient is currently in the recovery phase and is undergoing rehabilitation under my supervision. Due to the nature of the surgery, the patient requires at least 6 weeks of rest and limited mobility.

Recommended Sick Leave Duration: 6 weeks

The patient is expected to return to regular work activities on {{return\_date}}, provided they are medically fit.

If any further information is required, please feel free to contact my office.

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### Doctor's Information

- **Doctor's Name:** Dr. med. Fredy Meyer