

[FACILITY LOGO]

[Facility Name]
[Facility

Address] **MEDICAL CERTIFICATE**

Date: [Date]

To Whom It May Concern,

This is to certify that I have seen _____, _____, _____ at _____ with
the following findings:

[Diagnosis]

Impressions / Recommendations / Treatment:

[Notes]

This certification is being issued for whatever legal official purpose it may serve.

Thank you,

[Digital Signature]

[Doctor's Full Name]

License No. [License No.]

Attending Physician