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 certifiation 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