

Republic of the Philippines
Province of Samar
MUNICIPAL HEALTH UNIT
Marabut, Samar

MEDICAL CERTIFICATE

(Date)

To Whom It May Concern:

THIS IS TO CERTIFY that _____ of _____
(Name of Patient) (Address)

Was examined and treated at the Municipal Health Office on _____, 20____
with the following diagnosis: _____
(Date)

And would need medical attention for _____ days barring
complication.

(Attending Physician)

(Attending Physician)