



# Medical Certificate

**Date:** \_\_\_\_\_

## To Whom It May Concern

This is to certify that \_\_\_\_\_ has been under my medical care  
and treatment since \_\_\_\_\_

I hereby certify that \_\_\_\_\_ is suffering  
from \_\_\_\_\_ and unable to perform any activity because of  
the aforementioned medical condition.

**Verify Details:**