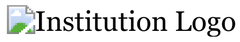

Medical Certificate

This certifies that:

[Full Name of the Patient]

This is to confirm that **[Full Name of the Patient]** has been under my medical supervision for the treatment of **[Medical Condition/Disease]** from **[Start Date]** to **[End Date]**.

It is recommended that the patient takes a rest for **[Number of Days]** days, effective from **[Rest Start Date]** until **[Rest End Date]**, and is advised to resume regular activities on **[Date]**.

Patient Name	[Full Name]
Age	[Age]
Gender	[Gender]
Diagnosis	[Medical Condition/Disease]
Treatment Period	[Start Date] to [End Date]
Rest Period	[Rest Start Date] to [Rest End Date]

[Doctor's Name]

Doctor's Signature

[Authorized Person's Name]

Authorized Signature

Institution Name: [Hospital/Clinic Name]

Address: [Address]

Contact Information: [Phone Number] | [Email]