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:

_____

_____

_____

And would need medical attention for _____ days barring complication.

(Attending Physician)

_____

(Attending Physician)