Disability Certificate

Doctor's name			
Address & Details		**Office Phone**	
		Office Fax	

Patient's name			**Patient**	
Company		**Date of Injury or illness**		☐ **Work related** ☐ **Non Work Related**

☐ This is to certify that _____ has been under my professional care, and was **totally** incapacitated from _____ to _____

☐ This is to certify that _____ has been under my professional care, and was **partially** incapacitated from _____ to _____

☐ This is to certify that _____ has been under my professional care, and **will be totally** incapacitated from _____ to _____

☐ This is to certify that _____ has been under my professional care, and **will be partially** incapacitated from _____ to _____

Remarks & Comments

Doctor's Signature		**Date**	