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MEDICAL CERTIFICATE

DATE: 19 107/20 20 21
The undersigned hereby certifies that Patient: Was examined by me on this date: According to my knowledge and as I was informed he/she was unfit for work From: To: 21 / 1/20.2. Date of return to work: 22 / 1/20 Date of return to work: 22 / 1/20 To: 21 / 1/20 To: 2
Nature of Illness / Operation
DR N.H KHOSA MBChB PR NO:0298018 Signature P.O. BOX 512

BENDOR PARK 0713

DR N.H KHOSA Pr No.: 0298018