MEDICAL CERTIFICATE

Issued by:

Doctor Name :

Address :

Contact :

Date :

Patient Details:

Full Name:

Age/Sex:

Address:

Medical Assessment:

This is to certify that I, _____, have examined **Mr./Ms.**_____ and found the patient to be:

☑ **Unfit for work/school** from _____ to _____.

☑ **Fit for work/school with light duties** (specify restrictions if any): _____.

Diagnosis/Reason:

_____

_____

Recommendations: [Rest, medication,etc.]

_____

Doctor's Signature