**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**