

# Employee Sick Leave Medical Certification

**Employee Name:**

**Employee ID/Number:**

**Department/Section:**

**Medical Condition / Diagnosis:**

**Date Examined:**

**Recommended Sick Leave Period:**

e.g. June 1 - June 5, 2024

**Remarks / Recommendations:**

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Attending Physician's Signature

**Physician's Name:**

**License Number:**

**Contact Number:**

**Date:**