Medical Assessment Certificate

For Employee Disability

Employee Information

Full Name:

_____

Employee ID / No:

_____

Date of Birth:

_____

Position / Department:

_____

Medical Assessment

Date of Examination:

_____

Nature of Illness / Disability:

Duration of Disability:

_____

Is the disability permanent?

Yes / No

Remarks / Recommendations:

Physician Details

Physician Name:

_____

Medical License No.:

_____

Contact Information:

_____

Clinic/Hospital Name:

_____

_____

Date

_____

Physician's Signature & Stamp