Medical Certificate

Employee Illness Verification

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Employee ID / Number: _____

MEDICAL DETAILS

Date Examined: _____

Illness / Condition: _____

Duration of Illness: _____

Is the employee fit to return to work? _____

Medical Advice / Restrictions: _____

CERTIFICATION

Date Issued: _____

_____

Doctor's Name & Signature

_____

Medical License Number