Clinic Health Clearance

For Sickness Absence

Patient Information

Full Name

Date of Birth | Gender

Patient ID / Reference No.

Sickness Absence Details

Diagnosis / Nature of Illness

Date of Onset | Date Returned to Work/School

Total Days Absent

Clearance Statement

I certify that the above-named patient is now clinically cleared to return to work/school.

Physician's Signature

Date Issued

Physician Details

Name of Attending Physician

Clinic / Facility Name

License Number

Contact Information

Note: This form is for official documentation only. Attach to patient's records as required.