Illness Confirmation Certificate

for Work Absence

Employee Name: _____

Date of Birth: _____

Position / Department: _____

Employer: _____

Date Examined: _____

Period of Absence: _____ **to** _____

Medical Practitioner Name: _____

License/Reg. No.: _____

Comments: _____

Medical Practitioner Signature

_____

Date:

_____

Employee Signature (if required)

_____

Date:

_____