Medical Assessment Form for Sick Leave Approval

Employee Name

Employee ID / Number

Department

Designation

Date of Assessment

Medical Condition (brief description)

Symptoms

Medical Assessment / Findings

Doctor's Recommendations

Recommended Sick Leave Period

e.g. From 2024-06-01 to 2024-06-05

Fit to Return to Work Date

Medical Practitioner Details

Name of Doctor

Medical Registration Number

Clinic / Hospital Name

Doctor's Signature

Date