

Medical Certificate

(For Employee Sick Leave)

Employee Name: _____

Date of Birth: _____

Position/Department: _____

Company Name: _____

Date of Consultation: _____

Expected Period of Absence: _____

From: _____ To: _____

Reason for Absence:

Additional Comments:

Physician's Signature

Date

Physician Name: _____

Medical License No.: _____

Clinic Address: _____

Contact Number: _____