Dr. _____ Qualifications: _____

Registered with: _____ Medical Council Reg. No.: _____

Clinic: _____ Phone: _____

MEDICAL CERTIFICATE

For leave on medical grounds

I, Dr. _____, after careful personal examination on _____, certify that Mr / Ms _____, son / daughter / wife of _____, aged _____ years, residing at _____, whose signature or thumb impression is given below, is suffering from _____, and that a period of absolute rest of _____ day(s), from _____ to _____, is necessary for the restoration of his / her health.

Identification mark(s): 1) _____ 2) _____

Certificate No.: _____ Place: _____ Date: _____

Signature or thumb impression of the patient

Signature and stamp of the doctor with registration number

Valid only when completed and signed by a registered medical practitioner after examining the patient.

Format from the Clinic Resource Hub by ClinicManagerPro (clinicmanagerpro.com/clinic-resources/).

Dr. _____ Qualifications: _____

Registered with: _____ Medical Council Reg. No.: _____

Clinic: _____ Phone: _____

CERTIFICATE OF FITNESS TO RESUME DUTY

After an illness or medical leave

I, Dr. _____, certify that I examined Mr / Ms _____, son / daughter / wife of _____, aged _____ years, whose signature or thumb impression is given below, in person on _____, and found that he / she has recovered from _____ and is fit to resume duty with effect from _____.

Identification mark(s): 1) _____ 2) _____

Certificate No.: _____ Place: _____ Date: _____

Signature or thumb impression of the patient

Signature and stamp of the doctor with registration number

Valid only when completed and signed by a registered medical practitioner after examining the patient.

Format from the Clinic Resource Hub by ClinicManagerPro (clinicmanagerpro.com/clinic-resources/).

Dr. _____ Qualifications: _____

Registered with: _____ Medical Council Reg. No.: _____

Clinic: _____ Phone: _____

MEDICAL FITNESS CERTIFICATE

For employment, admission, sports or travel

I, Dr. _____, certify that I examined Mr / Ms _____, son / daughter / wife of _____, aged _____ years, whose signature or thumb impression is given below, in person on _____, and that at the time of examination he / she was in good health and fit for _____.

Height	_____ cm	**Weight**	_____ kg
Blood pressure	_____ mm Hg	**Pulse**	_____ /min
Vision (R / L)	_____ / _____	**Remarks**	_____

Identification mark(s): 1) _____ 2) _____

Certificate No.: _____ Place: _____ Date: _____

Signature or thumb impression of the patient

Signature and stamp of the doctor with registration number

Valid only when completed and signed by a registered medical practitioner after examining the patient.

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