MEDICAL CERTIFICATE

Hospital Name

Company address goes, City, State, Zip Code here,
Phone: (123) 456 7890, (321) 654 9870

To Whom it May Concern:

This is to certify that (Name of Patient) of (Address)

Was examined and treated at the Municipal Health Office on ,20 with the following diagnosis

And would medical attention for (Attending Physician) days barring complication.

5-8-2016

(DATE)

(Attending Physician)