HOSPITAL NAME HERE

MEDICAL CERTIFICATE

This is to certify that on _____ [date] I have examined _____

[Name of the person] who according to my opinion is _____

[Mention physically fit or unfit. If suffering from any illness mention the name of it].

Hence he will be/ was _____ [if physically unfit then

Mention you would be unable to attend work or school] from _____ [Date] to

_____ [Date], no need to mention this date if physically fit].

Comments: _____

_____

[If necessary, mention other comments regarding the person's health]

Diagnosis: _____

_____

Date:

_____

Doctor's Signature

123 main street, New York City, USA

+1234567890