Medical Certificate Forms For Leave

Patient Information

- **Name:** _____
- **Date of Birth:** _____
- **Employee ID (if applicable):** _____
- **Department:** _____
- **Position:** _____
- **Contact Number:** _____

Medical Condition

- **Diagnosis:** _____
- **Description of Illness/Injury:**
- **Date of Onset:** _____
- **Date of Medical Consultation:** _____
- **Expected Duration of Absence:**

  From _____ To _____

Treatment Plan

- **Medications Prescribed:**
- **Required Rest/Recovery Period:**
- **Follow-up Appointment Date:** _____

Physician's Information

- **Name:** _____
- **Qualification/Specialization:** _____
- **Medical License Number:** _____
- **Contact Number:** _____

Copyright @ SampleTemplates.com

- **Signature: _____**
- **Date: _____**

Employer Certification

- **Received by (Name & Title): _____**
- **Date of Receipt: _____**
- **Signature: _____**

Employee Acknowledgment

- **I acknowledge that the information provided is accurate to the best of my knowledge and will be used to assess my leave request.**
- **Signature: _____**
- **Date: _____**

Copyright @ SampleTemplates.com