

## **SICKNESS CERTIFICATE**

Patient Name \_\_\_\_\_

1. Fitness to work

I confirm that the above is fit to return to work.

Yes \_\_\_\_\_ No \_\_\_\_\_

If No, I estimate the return to work by \_\_\_\_\_

2. Illness (complete this section only with specific consent of patient)

On the basis of my review, I conclude that the patient was ill during the time noted above.

Yes \_\_\_\_\_ No \_\_\_\_\_

Check only statement(s) which apply:

\_\_\_\_\_ Review include Patient History

\_\_\_\_\_ Review includes Examination

\_\_\_\_\_ Objective Evidence Confirmed (signs or investigational data)

3. Duration of Absence, According to the Patient From \_\_\_\_\_ To \_\_\_\_\_ Inclusive.

Name of Physician \_\_\_\_\_  
(Print)

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_