MEDICAL CERTIFICATE

I attended ____________________ on ________________
(date)

Due to illness/injury the following restrictions apply

from ____________________ :
(date)

____

____

____

____

- Next clinical review __________________ **or,**
  (date)
- Fit for full duties ____________________ **or,**
  (date)
- He/she informed me that he/she was not able to be at work

  from ____________ to ___________ due to illness/injury.
  (date) (date)

Signed ____________________________________

Print ____________________________________

Note: Medicare does not insure completion of this certificate.
You can expect to be billed directly for this service.

MEDICAL CERTIFICATE

I attended ____________________ on ________________
(date)

Due to illness/injury the following restrictions apply

from ____________________ :
(date)

____

____

____

____

- Next clinical review __________________ **or,**
  (date)
- Fit for full duties ____________________ **or,**
  (date)
- He/she informed me that he/she was not able to be at work

  from ____________ to ___________ due to illness/injury.
  (date) (date)

Signed ____________________________________

Print ____________________________________

Note: Medicare does not insure completion of this certificate.
You can expect to be billed directly for this service.