

# Medical Certification Template

## Personal Details

- Full Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Address: \_\_\_\_\_
- Contact Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_

## Medical Practitioner Information

- Practitioner Name: \_\_\_\_\_
- Practice Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Email: \_\_\_\_\_

## Medical Condition

- Diagnosis: \_\_\_\_\_
- Date Diagnosed: \_\_\_\_\_
- Treatment Plan: \_\_\_\_\_
- Expected Recovery Date: \_\_\_\_\_

## Certification Information

- Condition Description: \_\_\_\_\_
- Is the Condition Temporary?  Yes  No
- Is the Condition Permanent?  Yes  No

## Additional Information

- **Notes/Comments:** \_\_\_\_\_
- **Physical Limitations:** \_\_\_\_\_

### Signature

- **Physician Signature:** \_\_\_\_\_
- **Date:** \_\_\_\_\_