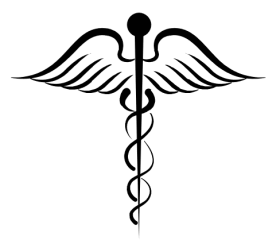
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| --- |
| **DOCTOR NAME**  Doctor Qualifications  Clinic Address |

**DOCTOR’S NOTE**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ provided medical care to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. It certifies that for medical reasons, this patient will not attend work, starting on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |
| --- |
| Given the health information before me (indicate all that apply): |
| The patient may return to work with/without restrictions on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| The patient needs further medical assessment before returning to work. |
|  |
| My opinion is based on the factors indicated below: |
|  |
|  |
|  |
|  |
| Date of next appointment is (indicate n/a if not applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |



Regards,

[Physician’s name]

**DOCTOR’S NOTE**

|  |
| --- |
| Doctor Name  Doctor Qualifications  Clinic Address |

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ provided medical care to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. It certifies that for medical reasons, this patient will not attend work, starting on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |
| --- |
| Given the health information before me (indicate all that apply): |
| The patient may return to work with/without restrictions on \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| The patient needs further medical assessment before returning to work. |
|  |
| My opinion is based on the factors indicated below: |
|  |
|  |
|  |
|  |
| Date of next appointment is (indicate n/a if not applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

Regards,

[Physician’s name] [Physician’s Sign]