

MEDICAL CERTIFICATE OF SICKNESS / EMPLOYMENT INJURY

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Any person who knowingly makes a false representation for the purpose of obtaining a benefit commits a criminal offence punishable by a fine or imprisonment or both.

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TO BE COMPLETED BY MEDICAL PRACTITIONER

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NOTE: Please tick appropriate box:

NOTE: Please tick appropriate box:

Sickness Benefit Employment Injury

Sickness Benefit Employment Injury

Name of Insured Person

Name of Insured Person

I hereby certify that on

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

 I examined the above named person

I hereby certify that on

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

 I examined the above named person

dd mm yy

dd mm yy

at..... and he / she

at..... and he / she

is suffering from

is suffering from

which is a medical condition surgical procedure and is incapable of working.

which is a medical condition surgical procedure and is incapable of working.

In my opinion he / she will be fit to resume work on

| | | | | | |
|--|--|--|--|--|--|
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In my opinion he / she will be fit to resume work on

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|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

dd mm yy

dd mm yy

Any other remarks.....

Any other remarks.....

I declare that the information given above is true and accurate to the best of my knowledge and belief.

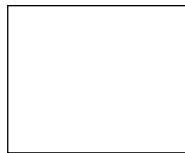
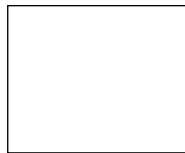
I declare that the information given above is true and accurate to the best of my knowledge and belief.

Medical Practitioner's Name

Medical Practitioner's Name

Address

Address



*Doctor's Stamp /
Registration No.*

*Doctor's Stamp /
Registration No.*

Signature

Signature

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

dd mm yy

| | | | | | |
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|--|--|--|--|--|--|

dd mm yy