

# MEDICAL CERTIFICATE

THIS CERTIFICATE IS TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

Full name of Named Person .....

Contract Number ..... Named Person's Usual Occupation .....

I have examined the Named Person on

Is the Named Person still totally disabled from working Yes  No

If NO please complete REVERSE SIDE of this medical certificate

Named Person is totally disabled from working from

What is the nature of the Named Person's disability?  
.....

What treatment/medication is the Named Person receiving?  
.....

Has the Named Person been to a specialist? Yes  No

If YES, please advise the name of the specialist and the date the Named Person last saw the specialist  
.....

Is the Named Person attending a rehabilitation programme? Yes  No

If YES, please provide details of any rehabilitation programmes they are attending below:  
.....

Date of next review

I certify to the best of my belief the foregoing statements are correct.

Name (please print) .....

Signature .....

Date .....

Address .....

Qualifications .....

Medical Practitioners Stamp

28/1/20  
SW



# MEDICAL CERTIFICATE FOR PARTIAL DISABLEMENT (ABLE TO ATTEND LIGHT DUTIES)

THIS CERTIFICATE IS TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

Full name of Named Person .....

Contract Number ..... Named Person's Usual Occupation .....

I have examined the Named Person on

What is the nature of the Named Person's disability?  
.....

Named Person is partially disabled from working from

Is there a documented Return to Work programme in place Yes  No

If yes please provide us with a copy of the programme

OR

The Named Person is fit to attend:  Hours per day  Days per week

Please describe limitations of work:  
.....  
.....  
.....  
.....

Date of next review

I certify to the best of my belief the foregoing statements are correct.

Name (please print) .....

Signature .....

Date .....

Address .....

Qualifications .....

Medical Practitioners Stamp