HOSPITAL NAME

Company address goes, City, State, Zip Code here,
Phone: (123) 456 7890, (321) 654 9870

MEDICAL CERTIFICATE

To Whom it May Concern:

This is to certify that _____ of _____
(Name of Patient) (Address)

Was examined and treated at the Municipal Health Office on _____ , 20____ with the following diagnosis
(Date)

_____

_____

_____

And would medical attention for _____ days barring complication.
(Attending Physician)

9-3-2016

(Date)

(Attending Physician)