MEDICAL CERTIFICATE FOR LEAVE OR EXTENSION OF LEAVE

Signature / thumb impression of patient

I, Dr _____ Authorized medical

Attendant / Registered Medical Practitioner after careful personal examination Of the case hereby

certify that Sh / Smt. _____

Working in _____ whose signature

Is give above is suffering from _____ and I consider

That a period of absence from duty of _____ days with effect from _____ is

Absolutely necessary for the restoration of his / health

_____

Place: _____

(SEAL)

Date:

_____

Authorized Medical Attendant

_____

Registered Medical Practitioner