

Attending Physicianâ€™s Report

Patient Information

Full Name:

Date of Birth:

Patient ID/Number:

Medical Details

Date of Examination:

Diagnosis:

Treatment Provided:

Medications Prescribed:

Is patient able to work?:

- Yes
- No

Remarks:

Physician Information

Physicianâ€™s Name:

Physicianâ€™s Signature:

Date:

Submit Report