

# Medical Certificate

**Patient Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_

**Gender:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date Examined:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Remarks /  
Recommendations:** \_\_\_\_\_

This is to certify that the above-named patient was examined and is:

\_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician's Name & Signature:** \_\_\_\_\_

**PRC No.:** \_\_\_\_\_