MEDICAL STATEMENT

Name of Center: _____ District: _____

Province: _____ Date: _____

I certify that [MR] [MRS] [MISS] _____ SEX _____ AGE _____

OF _____ HAS REPORTED

TO THIS HEALTH FACILITY ON THE _____/ _____/ _____ AT [TIME] _____AM/ PM.

PRESENTED WITH COMPLAINS OF (HISTORY)

_____
_____
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_____

FINDINGS ON EXAMINATION

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DIAGNOSIS (BELIEVE TO BE SUFFERING FROM, BASED ON THE FINDINGS)

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_____

RECEIVED TREATMENT (OUTLINE THE TREATMENT & MANAGEMENT OF THE CONDITION RECEIVED.

_____
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_____

SPECIAL ADVICE BASED ON CONDITION

1. THE OFFICER CAN REPORT TO WORK / SCHOOL : ☐
2. THE OFFICER SHOULD SEE A DOCTOR/ REFERED TO SEE A DOCTOR : ☐
3. THE OFFICER IS GIVEN SICK LEAVE

: ☐ 1 DAY SICK LEAVE
: ☐ 3 DAYS SICK LEAVE
: ☐ 5 DAYS SICK LEAVE

Any special instruction (For students)

_____
_____
_____
_____
_____

_____
Name & Signature of Officer In Charge of Center

Note: A medical Report can only be obtained from a Medical Practioneer/ Doctor.