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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Printable Doctor's Sick Note** | | | | | | | | | | | | | | | | |
| **Doctor’s Full Name:** | | | |  | | | | | | **License Number:** | | |  | | | |
| **Specialization:** | | | |  | | | | | | **Contact Information:** | | |  | | | |
| **Address of Practice:** | | | |  | | | | | | **Today’s Date:** | | |  | | | |
| **To Whom It May Concern,** | | | | | | | | | | | | | | | | |
| **Patient’s Information:** | | | | | | | | | | | | | | | | |
| **Full Name:** | |  | | | | | | | | **Date of Birth:** | | |  | | | |
| **Address:** | |  | | | | | | | | **Contact Number:** | | |  | | | |
| **Medical Evaluation:** | | | | | | | | | | | | | | | | |
| **Date of Examination:** | | | | | |  | | | | | | | | | | |
| **Symptoms / Conditions:** | | | | | |  | | | | | | | | | | |
| **Duration of Symptoms:** | | | | | |  | | | | | | | | | | |
| **Possible Cause:** | | | | | |  | | | | | | | | | | |
| **Treatment / Recommendations:** | | | | | |  | | | | | | | | | | |
| **Medical Advice and Restrictions:** | | | | | | | | | | | | | | | | |
| **Physical Activity Level:** | | | | |  | | | | | | | | | | | |
| **Work / Study Restrictions:** | | | | |  | | | | | | | | | | | |
| **Medications Prescribed:** | | | | |  | | | | | | | | | | | |
| **Follow-Up Appointment:** | | | | |  | | | | | | | | | | | |
| **Additional Notes:** | | | | |  | | | | | | | | | | | |
| **Certification of Illness:** | | | | | | | | | | | | | | | | |
| I, Dr. |  | | | | | | | hereby certify that I have examined | | | | | | |  | |
| , and in my professional opinion, they are | | | | | | |  | | fit to attend work / school due to the aforementioned | | | | | | | |
| medical condition. | | | | | | | | | | | | | | | | |
| The anticipated period of absence from work / school is from | | | | | | | | | | |  | | | to | |  |
| **Doctor’s Signature:** | | |  | | | | |  | | | | **Signing Date:** |  | | | |