PHYSICIANS CERTIFICATE
(WORK EXCUSE)

This is to certify that _____ was examined by me on
(Name of Employee/Patient)
_____. He/She is ***under my care and unable to work*** due to his/her illness or injury.
(Date)

Complete one of the following:

_____ He/She can return to work on _____ with no restrictions unless noted below.

_____ He/She is scheduled for a follow-up visit in this office on _____ at which time a determination will be made regarding his/her return to work. He/She should not return to work prior to this follow-up visit.

Other Comments/Instructions:

_____
_____
_____
_____

_____ _____
Physician's Signature Date Signed

_____
Printed or Typed Name of Physician

City of Hot Springs
Human Resources Department
Phone (501) 321-6841
Fax (501) 321-6769