

MEDICAL CERTIFICATE OF CAPACITY

Date of certificate/...../.....

Date of first consultation for the condition(s) covered by this certificate/...../.....

THIS IS TO CERTIFY THAT

I assessed (name),

who I consider has an active a medical condition resulting in the following limitations*:

Employment / in-person and worksite activities:

☐ FIT, ☐ UNFIT, ☐ FIT WITH RESTRICTIONS, ☐ N/A

Employment / online or home-based activities:

☐ FIT, ☐ UNFIT, ☐ FIT WITH RESTRICTIONS, ☐ N/A

Education / in-person, on-site, and placement activities:

☐ FIT, ☐ UNFIT, ☐ FIT WITH RESTRICTIONS, ☐ N/A

Education / online activities, assignments, and examinations: UNFIT

☐ FIT, ☐ UNFIT, ☐ FIT WITH RESTRICTIONS, ☐ N/A

from/...../..... to/...../..... (inclusive)

RESTRICTIONS: (if fit with restrictions)

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.....
.....
.....
.....
.....

* Limitations means:

"FIT" (no restrictions), "FIT WITH RESTRICTIONS", "UNFIT", or "NOT APPLICABLE (N/A)"

Certifying doctor's signature:

CERTIFYING DOCTOR'S DETAILS

(Please print clearly or use a stamp)

Name
Specialty
Provider number/identifier
Address
Telephone
Fax
Email

*Strike through if not applicable

Issued without alteration or erasure.