

# Doctor's Certification

**Patient Name:**

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**Date of Birth:**

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**Diagnosis/Condition:**

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**Summary of Medical Evaluation:**

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**Recommended Treatment:**

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**Start Date:**

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**Expected Duration:**

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**Medical Practitioner's Name:**

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Doctor's Signature

Date

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- This certification must be completed and signed by a licensed medical practitioner.
- Ensure all relevant fields are filled in clearly to avoid delays in processing.
- Attach any supporting documents or test results as necessary.
- False certification is subject to penalties as per applicable laws and regulations.
- Keep a copy of this document for your own records.