MEDICAL CERTIFICATE

illness / accident

I the undersigned, Doctor .....

Certify that ☐ Mr ☐ Ms ..... (*full name*)

Is suffering from illness / was involved in an accident.

His/her working capacity is :

0 % from .....(date) to .....(date) included*

.....% from .....(date) to .....(date) included*

100 % from .....(date)

**The inital duration of the certificate may not exceed one month. If the absence continues, a further certificate shall be provided every month.*

..... (*town*)

..... (*date*)

Doctor's signature and official stamp: