

MEDICAL CERTIFICATE

I hereby waive all rights and privileges pertaining to professional confidence between physicians and patients and the physician accomplishing this form is authorized to answer in detail all questions contained herein.

Signature of Patient

NB: Attending physician should fill blanks below. Every detail should be answered to avoid delay in action on application for leave submitted by the patient.

(Name of Patient) of the Bureau of Elementary Education, Account of illness.

I hereby certify that I was the patient's actual attending physician from ... 20 ... to ... 20 ... inclusive, and from my professional knowledge of the case, the following statements are submitted, as contemplated by the provisions of Section 8, of the Civil Service Rule XVI:

Name of Disease or Disability:
Nature of Disease or Disability:

(Under the heading, in addition to giving fully the etiology of the disease or disability the physician must either state in the language of the Executive Order: "There are no indications whatever that the disease named due to immoral or vicious, or give the indications.)

HISTORY:

(If Maternity) Probable date of Delivery: ... 20 ...

Laboratory test or examination was made in this case

The applicant was confined in ... from ... 20 ... to ... 20 ...

I hereby certify that the above statements are complete and true in every detail and that in consequence of the disease or disability above specified, the applicant was ill and unable to be on duty on account of illness from ... 20 ... to ... 20 ...

Date: ... 20 ...
Affix a documentary stamp to the original

(Signature of Physician)

(Address)