Medical certificate

Issued _____

Certificate no. _____

Patient	Date of birth	PPS no.
Address		

Employer, if disclosed _____

Occupation _____

Issued by the clinician named below for the stated period and purpose. Share it only with the employer, insurer or agency the patient names.

Certification

Unfit for work from _____

To _____

Fit to return on _____

Restrictions on return _____

Review required _____

The nature of the incapacity is disclosed to the patient only. A copy is furnished to the Department of Social Protection on request (S.I. No. 142 of 2007).

☐ First certificate for this illness ☐ Continuation ☐ Final, fit to return

Date _____

Signature _____

Practice stamp

IMC no. _____