# Fitness for Work Certificate

**Purpose:** This certificate is issued as an official confirmation of an individual’s physical and/or mental ability to perform occupational duties, following a medical assessment conducted by a licensed healthcare provider.

## Patient Information

|  |  |  |
| --- | --- | --- |
| **Full Name** | **Date of Birth** | **Employee ID** |
| {fullName} | {dateOfBirth} | {employeeId} |

## Medical Assessment

**Assessment Date:** {assessmentDate}

**Conducted By:** Dr. {physicianName}, {physicianTitle}

### Findings:

* **General Health Condition:** {generalCondition}
* **Relevant Medical History:** {medicalHistory}
* **Medications (if any):** {medications}

### Work Capability

{#isFitForWork}**This individual is deemed medically fit to perform work-related tasks without restrictions.**{/isFitForWork}

{^isFitForWork}**This individual is currently not fit to perform work-related tasks.**{/isFitForWork}

{#restrictions}

#### Conditional Fitness Note

The individual is fit to work under the following restrictions or limitations:

* {description}

{/restrictions}

### Recommended Review Date

{reviewDate}

## Physician’s Declaration

I hereby certify that I have personally examined the individual named above and that the above information is true and accurate to the best of my knowledge.

**Physician Name:** {physicianName}

**License Number:** {licenseNumber}

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** {issuedDate}

*This document is confidential and intended solely for the review of the individual, employer, and necessary third parties.*