INSERT DR'S LAST NAME, FIRST NAME, **MD**

INSERT DR'S ADDRESS AND SUITE #

INSERT CITY, STATE AND ZIP CODE

(555) 555-5555 **PHONE** (555) 555-5555 **FAX**

Certificate of Medical Consultation:

_____ was under my care on _____ he/she will be able to return to work/school on _____.

Physician's Comments:

_____

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Rx _____

INSERT DR'S LAST NAME, FIRST NAME **MD**