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