PTTEP Medical Certificate Form for Returning to Work

To be filled out by PTTEP Approved Doctor (PAD) only

I, Dr. _____ medical license no. _____

name of hospital _____contact no._____

certify that patient's name: _____ age: _____

was under my care for the diagnosis of _____

☐ Out-patient from date _____ to _____ ☐ In-patient from date _____to _____

Treatment in detail:

_____

_____

_____

_____

Medical Fitness Assessment:

☐ Fit to return to normal work.

☐ Fit to return to work with restriction.

- ☐ Limit of physical activity/exertion; provide detail_____
- ☐ Limit shift work or working hours; provide detail _____
- ☐ Others, please specify type of restriction _____

☐ Unfit to return to work

Next appointment:

This patient needs to return for follow-up review on date _____

PTTEP APPROVED DOCTOR NO.....

Signature

_____

(Dr. , MD)

Date _____