[Your Clinic/Institution Name]
[Address Line 1]
[Address Line 2]
[City, State, ZIP Code]
[Phone Number]
[Email Address]
[Date]

MEDICAL CERTIFICATE
Patient Name: [Patient's Name]
Date of Birth: [Patient's DOB]
Gender: [Patient's Gender]
Patient ID: [Patient ID/Record Number]
Date of Examination: [Examination Date]
Diagnosis: [Medical Condition/Diagnosis]
Treatment Duration: [Start Date] to [End Date]
Recommended Rest: [Number of Days/Weeks]
Fitness for Work: [Yes/No]
Doctor's Name: [Doctor's Name]
Doctor's Qualification: [Doctor's Qualification]
Medical Registration No: [Registration Number]
Signature: [Signature or Digital Signature]

Remarks:
[Additional Notes, if any]
Seal of the Clinic/Institution

[Disclaimer: This certificate is issued for the purpose of medical documentation only.]