

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



