

# MEDICAL CERTIFICATE / DOCTOR'S LETTER

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

## Medical Information:

This is to certify that the above-named patient has been under my care. After thorough examination and review of the medical history, it is my professional opinion that the patient is fit to perform the duties required of their occupation and daily activities, subject to any limitations or restrictions outlined herein. This certificate is issued in accordance with applicable laws and regulations in Canada and is intended solely for the use of the patient and relevant entities as authorized by law.

## Diagnosis (if applicable):

\_\_\_\_\_

## Functional Limitations / Restrictions:

\_\_\_\_\_

## Prognosis / Expected Duration of Condition (if any):

\_\_\_\_\_

## Treatment / Recommendations:

\_\_\_\_\_

## Additional Notes:

\_\_\_\_\_

## Confidentiality and Compliance Notice:

This letter and the information contained herein are confidential and intended solely for the recipient. Disclosure, copying, or distribution without prior written consent from the undersigned physician is prohibited. This certificate complies with the Personal Information Protection and Electronic Documents Act (PIPEDA) and relevant provincial privacy legislation in Canada.

## Physician Information:

Full Name: \_\_\_\_\_

Medical License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Email: \_\_\_\_\_

## Certification Statement:

I certify that I am a licensed medical practitioner authorized to practice in Canada, and that the information provided in this letter is true and accurate to the best of my knowledge and belief. This certificate is provided without prejudice and solely for the purpose described herein.

**Signature and Stamp:**

**Physician's Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

Medical Stamp / Seal:

\_\_\_\_\_

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