Republic of the Philippines
Province of Samar
MUNICIPAL HEALTH UNIT
Marabut, Samar

MEDICAL CERTIFICATE

_____
(Date)

To Whom It May Concern:

THIS IS TO CERTIFY that _____ of _____
(Name of Patient)

_____ was examined and treated at the Municipal Health Office on
(Address)

_____, 20_____ with the following diagnosis:
(Date)

_____

_____

_____

and would need medical attention for _____ days barring complication.

_____
(Attending Physician)