# Request for Medical Certificate

| **PATIENT TO COMPLETE** | | **For Internal Use Only** |
|---|---|---|
| 1 | Patient Name: _____<br>Patient Date of Birth: ___ / ___ / _____<br>Telephone Number: _____<br>Reason for Certificate: _____ | DETAILS checked by<br>S/R: _____ |
| 2 | Have you had a consultation with a clinician regarding this:<br>**YES ☐ Clinician Name: _____ NO ☐**<br>If no, please speak to a member of Reception | DETAILS checked by<br>S/R: _____ |
| 3 | Have you self certified for 7 days? **YES ☐ NO ☐**<br>If yes, please confirm the dates: **From** ___ / ___ / _____ **To** ___ / ___ / _____<br>*If no, please be advised you can self certify for 7 days without a medical certificate* | DATES checked by<br>S/R: _____ |
| 4 | Have you been discharged from hospital? **YES ☐ NO ☐**<br>If yes, please confirm the dates you were in hospital:<br>From ___ / ___ / _____ To ___ / ___ / _____<br>If yes, please confirm the reason/procedure: _____ | DATES checked by<br>S/R: _____ |
| 5 | Do you require an extension of an existing certificate? **YES ☐ NO ☐**<br>If yes, please confirm the dates of your current certificate:<br>From ___ / ___ / _____ To ___ / ___ / _____*<br>*__Please note:__ *Medical certificates cannot be predated and a new certificate cannot be issued until your current one has expired.* | DATES checked by<br>S/R: _____ |
| **6** | Period of absense required: **From** ___ / ___ / _____ **To** ___ / ___ / _____ | DATES checked by<br>S/R: _____ |
| **7** | If requesting a certificate to **return to work**,<br>please confirm the date required: ___ / ___ / _____ | DATES checked by<br>S/R: _____ |
| 8 | **Patient Declaration:** I confirm that the information given is true and accurate and I understand that this is a legally binding declaration.<br>Patient Signature: _____<br>Date: ___ / ___ / _____<br>***Please note: These requests usually take 3-5 working days to action.*** | RECORDS updated by<br>S/R: _____ |