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| **XXX INPUT PRACTICE LETTERHEAD** | |
| **I, THE UNDERSIGNED HEREBY CERTIFY THAT** | |
| NAME OF PATIENT: | ID NO: |
| **ABOVE PATIENT UNDERWENT A TELEPHONIC CONSULTATION WITH ME ON** | |
| DATE AND TIME OF TELECONSULTATION: |  |
| **PERIOD OF ABSENCE FROM DUTY AS STATED BY THE PATIENT** | |
| FROM: | UP TO AND INCLUDING: |
| **ACCORDING TO MY TELEPHONIC CONSULTATION SICK LEAVE IS RECOMMENDED** | |
| FROM: | UPTO AND INCLUDING: |
| **NATURE OF ILLNESS / OPERATION / INJURY** | |
| **(IT IS RECOMMENDED TO RETAIN A PHOTOCOPY OF THE CERTIFICATE ON THE PATIENTS FILE)** | |
| ICD 10 CODE: | |
| DIAGNOSIS: |  |
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|  |  |
| DATE TO RETURN FOR FOLLOW UP: |  |
| *At the end of the telephonic consultation, the patient agreed that the content of this certificate may be released to their employer or a third party (delete if inapplicable)* | |
| *At the end of the telephonic consultation the patient agreed with the content of the certificate (delete if inapplicable)* | |
| **PRACTITIONER’S SIGNATURE AND DEGREE** |  |
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|  |  |
| *(Based on the information provided to me by the patient during the telephone conversation and in my professional opinion, based on acceptable medical grounds, the patient is/was unable to perform his/her normal duties on the dates specified, as a result of the illness/injury)* | |
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| **PRACTITIONER’S INITIAL & SURNAME IN LETTERS** | **DATE OF ISSUE (not to be backdated)** |
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