EMPLOYEE MEDICAL FORM.
NOTE: ALL FIELDS MUST BE FILLED-UP. FORM MUST BE NOTARIZED. DO NOT ACCEPT IMPROPERLY ACCOMPLISHED FORMS. THIS FORM MUST BE SUBMITTED WITHIN FIVE (5) DAYS FROM RETURN TO WORK, OTHERWISE, THE ABSENCE WILL BE CONSIDERED AS AN UNAUTHORIZED ABSENCE.

REPUBLIC OF THE PHILIPPINES)
CITY OF _____) SS.

SWORN STATEMENT

I, **DR.** _____INSERT NAME OF DOCTOR_____, Filipino, of legal age, and with clinic address at _____, after having sworn in accordance with law, hereby depose and state that:

1. I am a practicing physician with License No. _____ issued on _____ by the Professional Regulations Commission.

2. I have examined _____INSERT DATE OF EMPLOYEE_____, on _____INSERT DATE OF EXAMINATINON_____ at my clinic address above.

3. After my examination, I have found him/her to be suffering from:

INSERT PARTICULARS OF MEDICAL FINDINGS

4. From my examination, I have issued the following recommendation / prescription:

INSERT PARTICULARS OFRECOMMENDATIONS/MEDICATION PRESCRIBED

5. I am executing this Sworn Statement to attest to the truth of the foregoing facts, upon the request of _____INSERT DATE OF EMPLOYEE_____, as a requirement for his/her employment/employee records.

IN TESTIMONY WHEREOF, I have hereunto set my hand this _____ at _____.

AFFIANT FURTHER SAYETH NAUGHT.

_____
PRINT NAME AND SIGN ABOVE
Affiant

SUBSCRIBED AND SWORN to before me this _____ in the above-named jurisdiction, affiant exhibited to me his/her _____, issued at _____ on _____.

Doc. No. _____
Page No. _____
Book No. _____
Series of 2016.

I REFUSE TO SIGN THIS DOCTOR'S SWORN STATEMENT:

_____
Signature over printed Name & DATE