Cherrybrook Technology High School
28 - 44 Purchase Rd Cherrybrook. 2126
Ph: 9484 2144

MEDICAL CERTIFICATE

Doctor's name:..Date: ....

Address:..

I certify that on the above date I examined ....
(student's name)

☐ The patient is suffering from ....
(diagnosis provided with patient's consent where possible)

☐ Is suffering from a medical condition of a confidential nature.

In my opinion this condition will affect the completion of the following: (please tick)

	In minor way	Moderately	Severely
CLASS ATTENDANCE	☐	☐	☐
WRITTEN ASSIGNMENTS	☐	☐	☐
PRACTICAL ASSIGNMENTS	☐	☐	☐
PRIVATE STUDY	☐	☐	☐

For the period: .... to:...

EXAMINATIONS: The student is unable to sit for examinations on:....................................

OTHER REMARKS:...

....

....

....
Signature of medical practitioner

Doctor stamp (include provider number)

23 March 2023