# CERTIFICATE OF PROOF OF SICKNESS OR INJURY

## THIS IS TO CERTIFY THAT

NAME

ADDRESS

**IS UNFIT FOR WORK** ☐ **IS FIT FOR MODIFIED WORK** ☐

FOR DAYS FROM DD / MM / YYYY FOR DAYS FROM DD / MM / YYYY

## RECOMMENDED MODIFICATIONS TO WORK

## HEALTH PRACTITIONER TO COMPLETE

EXAMINATION DATE DD / MM / YYYY

ACC CLAIM
*(if applicable)*

NAME

PRACTICE

REGISTRATION NUMBER

SIGNATURE