

DOCTOR'S LETTER

Doctor's Name: _____
Registration Number: _____
Clinic/Hospital Name: _____
Clinic Address: _____
Phone Number: _____

Patient Information:

Full Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

Medical Assessment:

I hereby certify that I have examined the above-named patient and have found that they are suffering from a medical condition that may affect their ability to perform certain activities. This assessment is made based on the clinical findings and applicable tests. The patient's current medical status is as follows:

Recommendations:

Based on the above assessment, it is my professional opinion that the patient is fit/unfit to undertake the following activities, subject to the recommendations below.

Fitness to Work:

I certify that the patient is fit/unfit to return to work and perform duties as appropriate to their condition. Any necessary accommodations or restrictions are as follows:

Confidentiality Notice:

This letter contains confidential medical information intended solely for the use of the individual or entity to whom it is addressed. Disclosure, copying, or distribution without the explicit written consent of the patient or their legal guardian is prohibited and may be unlawful under applicable Australian privacy legislation.

Legal Compliance and Governing Law:

This letter is issued in accordance with the privacy, health, and professional regulations applicable within Australia. The contents herein are accurate to the best of my knowledge and reflect my professional judgement at the time of issuance. This document shall be governed by and construed in accordance with the laws of the Commonwealth of Australia.

DOCTOR'S SIGNATURE

PATIENT'S SIGNATURE

Signature: _____

Signature: _____

Doctor's Contact Information:

Phone: _____

Email: _____

Address: _____

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