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## MEDICAL CERTIFICATE FOR MISSED MAJOR ACADEMIC REQUIREMENT

**This form should be filled up by a licensed physician*

Date of Medical Consult: _____

Name of Patient/Student: _____

To whom it may concern:

I am certifying that I have a *bona fide* doctor-patient relationship with the aforementioned patient/student and have clinically assessed the patient/student with the following diagnosis:

_____

_____

_____

Due to the aforementioned condition, I am certifying that based on my professional opinion, the patient/student is NOT able to participate in the following missed major academic requirement (please indicate the course subject):

_____

Date of Missed Major Academic Requirement: _____

Sincerely,

_____ M.D.
(Full Name and Signature)

License No._____

PTR No. _____