MEDICAL CERTIFICATE FOR THE CONFIRMATION OF PERMANENTLY DISABLED STATUS

To be completed by Medical Practitioner

I _____Full Names and Surname,

registered Medical Practitioner, with Practice Number _____,

and practising at _____

_____(Physical Address)

with Postal Address _____

_____,

Do hereby declare that I have examined:

Mr / Ms _____, ID Number _____

and have found the said person to be permanently disabled.

The nature of the disability is as follows:

_____

_____

_____

_____

Signed at _____(place) on this day the _____

day of _____(month) _____(year)

_____ _____

Signature **Date**

Official Stamp of Medical Practitioner