WCP 4

WORKERS COMPENSATION FUND
RETURN TO WORK MEDICAL CERTIFICATE

(This form shall be filled by a medical practitioner)

First Name……………………….. Middle Name ……………………. Last Name ………………………
Date of birth ………………………………… Sex ………………… ID No………………………………

Name of the employer……………………………………………………………………………………….

Date of occurrence of an occupational accident or diagnosis of an occupational disease………………

Medical treatment file No.………………………………………….

I certify that ………………………………………………………. had an occupational accident/disease and he/ she is fit to return to work and resume to perform his/her duties without any limitations.

Name and Address of the health care provider ……………………………………………………………..

Name of the Medical practitioner…………………………………………………….Reg No...……………...

Designation……………………………….. Date…………………………

Signature and Official stamp ………………………………………………………………………...