

Medical Certificate of Fitness

Name of Employee	ID Number	Co. Number
John Doe	12345	67890
Jane Smith	23456	78901
Bob Johnson	34567	89012
Alice Brown	45678	90123
Charlie Davis	56789	01234
Eve White	67890	12345
Frank Green	78901	23456
Grace Black	89012	34567
Henry Blue	90123	45678
Ivy Red	01234	56789
Jack Purple	12345	67890
Karen Yellow	23456	78901
Leo Orange	34567	89012
Mia Silver	45678	90123
Noah Gold	56789	01234
Olivia Bronze	67890	12345
Peter Platinum	78901	23456
Quinn Diamond	89012	34567
Rachel Ruby	90123	45678
Sam Sapphire	01234	56789
Tina Emerald	12345	67890
Umar Topaz	23456	78901
Victor Amethyst	34567	89012
Wendy Garnet	45678	90123
Xavier Onyx	56789	01234
Yara Obsidian	67890	12345
Zoe Jasp	78901	23456
Adam Malachite	89012	34567
Bella Labradorite	90123	45678
Chris Hematite	01234	56789
Diana Lapis Lazuli	12345	67890
Ethan Turquoise	23456	78901
Fiona Aquamarine	34567	89012
George Peridot	45678	90123
Hannah Smoky Quartz	56789	01234
Ian Smoky Topaz	67890	12345
Jessica Citrine	78901	23456
Kevin Smoky Amethyst	89012	34567
Laura Smoky Quartz	90123	45678
Mark Smoky Topaz	01234	56789
Nancy Smoky Amethyst	12345	67890
Oscar Smoky Quartz	23456	78901
Pamela Smoky Topaz	34567	89012
Quinn Smoky Amethyst	45678	90123
Rachel Smoky Quartz	56789	01234
Sam Smoky Topaz	67890	12345
Tina Smoky Amethyst	78901	23456
Umar Smoky Quartz	89012	34567
Victor Smoky Topaz	90123	45678
Wendy Smoky Amethyst	01234	56789
Xavier Smoky Quartz	12345	67890
Yara Smoky Topaz	23456	78901
Zoe Smoky Amethyst	34567	89012
Adam Smoky Quartz	45678	90123
Bella Smoky Topaz	56789	01234
Chris Smoky Amethyst	67890	12345
Diana Smoky Quartz	78901	23456
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Wendy Smoky Quartz	23456	78901
Xavier Smoky Topaz	34567	89012
Yara Sm		

[illegible]

* The Employer to complete the information in the spaces marked with an * before sending the Employee for a medical examination

Declaration by the Medical Examiner:

I certify that I have, by examination and testing, using the above criteria specified by the employer, satisfied myself that the above mentioned employee is fit to perform the duties as described by the employer in the matrix above.

Occupational Medicine Practitioner/Occupational Health Nursing Practitioner: (Please Print Name)

Signature

Practice Number:

Date:

Address: