Place:

Date:

**MEDICAL FITNESS CERTIFICATE**

This is to certify that Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, currently residing  at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was on **Maternity Leave** for a period of 180 days with effect from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_. She is fit for duty from \_\_\_\_\_\_\_\_\_\_\_\_\_.

 Civil Surgeon

 Signature & Seal.