

**Social Security Board
PO Box 698
Road Town, Tortola
British Virgin Islands**

Medical Certificate

I certify that I examined
on and in my opinion, He/She was suffering from
.....
and was deemed incapable of work.

- *A. In my opinion, he/she will remain incapable of work for a further period ofdays
(not more than 14 days from the date of examination above.)
- *B. In my opinion he/she will be fit to resume work today/tomorrow on
(not more than 7 days from the date of examination above.)
- *C. In my opinion, he/she will be liable to be permanently incapable of work (where
incapacity has already lasted 6 months.)

Any other remarks by Doctor.....
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Doctor's Name:
(Please print)

Doctor's Signature Date.....

Address..... Telephone #