JASON BELIZAIRE, M.D.
Diplomate of the American Board of Internal Medicine

Woods Center
St. John's, Antigua
Tel: (268) 562-1168/1160
Fax: (268) 562-1200

September 8, 2020

To Whom It May Concern

Re: Hon Asot Michael

Dear Sir/Madam,

This letter is to certify that the Hon Asot Michael was seen by me at Mount St. John's Medical Center on September 03, 2020 with hypotension and chest pain. He has been placed on sick leave for 1 month.

Please feel free to contact me should you require any further information.

Sincerely,

Jason Belizaire M.D.

Section A
(To be completed by a State Registered Medical Practitioner)

Re: Mr/Mrs/Miss ....Asot Michael..........

I hereby certify that on ....3/9/20.......... 20.......... I examined you

and found that you are suffering from ....[illegible].......... In my

Opinion, you will be fit to resume work on ....3/16/20.......... 20..........

Occupational Injury ☐ Yes ☑ No

Name ....Jason Belizaire..........
(Please Print)

Address ....[illegible]..........

Signature ....[signature].......... Date..........3/9/20..........

Jason Belizaire M.D.
Woods Center
P.O. Box W698
St. John's, Antigua
(268) 562-1168

Section B
(Medical Certificate for employer)

Jason Belizaire M.D.
Woods Center
P.O. Box W698
St. John's, Antigua
(268) [illegible]

I hereby certify that on ....3/9/20..........20..........I examined ....Asot Michael..........and by reason of illness, he/she is incapacitated. In my opinion, he/she will be fit to resume work on ....3/16/20.......... .... 20............

Signature ....[signature].......... Date ....3/9/20..........

Dr. Jason Belizaire
Woods Centre, P.O. Box W698
St. John's, Antigua,
(268)562-1168

Receipt Number: 202674

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9/8/2020

Patient: Josette MICHAEL
\# 18 High Street

Chart #: MICJO003
Case #: 11579

Instructions:
Complete the patient information portion of your insurance claim form. Attach this bill, signed and dated, and all other bills pertaining to the claim. If you have a deductible policy, hold your claim forms until you have met your deductible. Mail directly to your insurance carrier.

Date	Description	Procedure	Modify	Dx 1	Dx 2	Check Number	Units	Charge
9/8/2020	Vitamin B12 Injection	VIT B12					8	400.00

Provider Information

Provider Name: Jason R. Belizaire
License: 7195
Insurance PIN:
SSN or EIN:

Total Charges:	$ 400.00
Total Payments:	$ 0.00
Total Adjustments:	$ 0.00
Total Due This Visit:	**$ 400.00**
Total Account Balance:	$ 400.00

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services described above. I also authorize the release of any information necessary to process this claim.

Patient Signature: ____________________ Date: __________