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# Department of Social Services

Walter Nisbeth Road #57, Philipsburg
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## Medical Report

All medical statements/reports received by the Department of Social Services shall be confidential. This information will be disclosed only as authorized by the applicant.

**SECTION I** – To be Completed by Applicant (Please print or type)
Please complete the following information and sign the medical agreement as a condition of applying for government aid.

Last Name: _____

Given Names: _____

Date of birth: ____/____/____ Place of birth: _____
Day Month Year

Nationality: _____ Sex: ( )Male ( )Female

Marital Status: ( )Single ( )Married ( )Widow(er)
( )Divorced ( )Living together ( )Separated

Address: _____
_____

Email address: _____

Telephone: Home: _____ Cell: _____ or _____
Work: _____ Family member: _____

### Agreement/Release of Information

I agree to remain under the care of my physician and follow the treatment exactly as prescribed. I hereby authorize and request my physician to release information regarding my medical condition to the Department of Social Services, and to report any change in the status of my condition that would impair my ability to maintain regular employment. I understand that failure to abide by the conditions set forth in this agreement are grounds for the Department to deny or cancel my aid. This report shall remain valid for three months (90 days).

_____ _____
Signature of Individual Date of Signature

(Continued on back)

**SECTION II - MEDICAL ASSESSMENT** — To be Completed by house doctor/medical Professional. All sections of this report must be completed in its entirety.

DATE OF COMPLETION OF MEDICAL ASSESSMENT: _____

1. In your professional opinion, is this individual MEDICALLY FIT to work? ( )YES ( )NO

2. Conditions: Yes or No required for each condition listed.
(a) Cardiovascular ( )YES ( )NO (provide condition)_____

(b) Neurological ( )YES ( )NO (provide condition)_____

(c) Musculoskeletal ( )YES ( )NO (provide condition) _____

(d) Respiratory ( )YES ( )NO (provide condition) _____

(e) Seizure ( )YES ( )NO (provide condition)_____

(f) Diabetes ( )YES ( )NO (provide condition)_____

(g) Dizzy/Fainting Spell ( )YES ( )NO (provide condition)_____

(h) Alcohol/Drug Abuse ( )YES ( )NO (provide condition)_____

(I) Mental Health Disorder: ( )YES ( )NO (provide condition)_____

(j) Other Medical Condition(s) (provide condition)_____

***For mental health disorders, please refer individual to Mental Health Foundation with a referral letter stating that the individual has a MENTAL disorder.***

3. Was any medication(s) prescribed relating to any condition indicated above in Question #2.
( )YES ( )NO

4. Could any of the prescribe medication affect the individual's performance on the labor market?
( )YES ( )NO

5. If the individual is not suitable for work, would you provide a recommended time frame when the individual can return to work and under what conditions. Please explain:

_____

_____

_____

**SECTION III** — Additional information, special restrictions, etc.

_____

_____

_____

**Please take note of the following:**
The undersigned medical provider declares, that the above mentioned questions have been truthfully answered. The willful participation of the medical provider in furnishing of incorrect information can result in annulment of the individual application and retrieving of aid received. Additionally, the information provided may be used to gain a 2nd opinion from the SZV Control Doctor.

_____ _____

Name & signature of Medical Provider Medical Provider's Address

**PLEASE MAINTAIN A COPY OF MEDICAL REPORT FOR YOUR RECORDS**