



## Department of Social Services

Walter Nisbeth Road #57, Philipsburg

Phone: 542 3561 or 543 7509 Fax: 543 7508 or 543 7511

Email: [infosod@sintmaartengov.org](mailto:infosod@sintmaartengov.org)

### Mental Health 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 - MENTAL HEALTH ASSESSMENT** — To be completed ONLY if individual has a Mental Health Disorder marked "YES" by house doctor/medical Professional

DATE OF COMPLETION OF MENTAL HEALTH ASSESSMENT: \_\_\_\_\_

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

2. Mental Health Disorder Diagnosis/Condition(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
Name & signature of Medical Provider

\_\_\_\_\_  
Medical Provider's Address

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