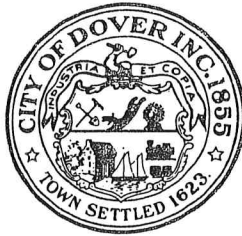


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# City of Dover, New Hampshire

## PUBLIC WELFARE DEPARTMENT MEDICAL REPORT

PATIENT'S NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

I hereby request the release by a doctor, hospital or clinic to the City of Dover Welfare Department or its authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization.

\_\_\_\_\_  
DATE PATIENT SIGNATURE  
.....  
TO THE PHYSICIAN

This person has applied to the City of Dover Welfare Department for financial assistance because he/she claims to be disabled and unable to work. He/she has selected you to complete this medical form to assist in determining his/her eligibility for general assistance based on his/her ability to work.

Is this person disabled? \_\_\_\_\_

If yes, check one: \_\_\_\_\_ temporarily \_\_\_\_\_ permanently \_\_\_\_\_ totally \_\_\_\_\_ partially

Date incapacity started: \_\_\_\_\_ Expected to end: \_\_\_\_\_

Can this person do any for of work? \_\_\_\_\_

Light duty/full-time/part-time? \_\_\_\_\_

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

If disabled, diagnosis in order of importance.

- 1.) \_\_\_\_\_ 3.) \_\_\_\_\_
- 2.) \_\_\_\_\_ 4.) \_\_\_\_\_

Medications Prescribed: \_\_\_\_\_

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
PHYSICIAN'S NAME