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City of Dover, New Hampshire

PUBLIC WELFARE DEPARTMENT

MEDICAL REPORT

PATIENT'S NAME: _____ **D.O.B:** _____

I hereby request the relase 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