DOCTOR'S STATEMENT

CONFIDENTIAL

Regarding: _____

Client ID #: _____

Birth Date: _____

Case Name: _____

Case Number: _____

Please return completed form to:

Name: _____

Office: _____

_____

_____

Phone: _____

Fax: _____

Please evaluate the medical or mental health condition of _____ so that we may determine his/her ability to work, participate in education, or attend training. A release of information follows below. Please complete and return this form by _____ . We appreciate and thank you for your assistance.

Sincerely,

_____ _____

DCF Staff Date

RELEASE OF INFORMATION

I, _____, hereby authorize _____,
(Name of Customer) (Name of Provider)

to provide the Department for Children and Families with information regarding my physical and/or mental conditions as requested on this letter. I release the above-named provider from any and all liability in reference to the release of the medical information provided in this release. I understand that this information will be used only in the administration of DCF programs.

_____ _____

Signature of Customer, Guardian, or Conservator Date

Case Name: _____ *Case Number:* _____

SECTION ONE

1. Medical/Mental Diagnosis/Condition: _____

_____

2. Date of Onset: _____

3. Anticipated Duration of the Diagnosis/Condition: _____

4. Can this Diagnosis/Condition be controlled with the following? Please mark all that apply.

_____ Medication _____ Surgery _____ Treatment

Please indicate the amount of recovery time after surgery or treatment, if applicable:

_____

SECTION TWO

5. Does the Diagnosis/Condition of this individual **prevent** participation in training class, work activity, or employment?

Yes _____ No _____

If yes, indicate the amount of time this Diagnosis/Condition will prevent him/her from these activities:

_____

****If Question 5 is marked YES, please skip to SECTION FOUR.****

SECTION THREE

6. Does the Diagnosis/Condition of this individual **limit** participation in a training class, work activity, or employment?

Yes _____ No _____

If yes, how many hours per day is the individual able to work or participate in training? _____

Please answer the following questions regarding the limitations of the individual.

A. How long can the individual stand at a time? _____ Sit? _____

B. What is the maximum weight the individual can lift? _____

C. Would specific accommodations be needed to work or participate in training? Yes _____ No _____

If yes, please explain: _____

D. Would this individual have difficulty dealing with the public or group situations? Yes _____ No _____

If yes, please explain: _____

E. Is the individual taking medications which would hinder performance? Yes _____ No _____

If yes, please explain: _____

F. Are there types of work or training that would be more appropriate than others? Yes _____ No _____

If yes, please explain: _____

SECTION FOUR

_____ _____

Medical Provider's Signature **Date**

_____ _____

Medical Provider's Printed Name & Title **Phone Number**