61 Locust Street, Suite 334
Dover, New Hampshire 03820-3704
(603) 516-6500
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s.gaston@dover.nh.gov or j.carnes@dover.nh.gov

City of Dover, New Hampshire

PUBLIC WELFARE DEPARTMENT

MEDICAL REPORT

PATIENT'S NAME:_____ **DOB:**_____

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.

_____ _____

APPLICANT SIGNATURE **DATE**

TO THE PHYSICIAN:

The person named above 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 [ ] Partially [ ] Totally

Date incapacity started:_____ Expected to end: _____

Can this person do any form of work? _____

Light duty/full-time/part-time? _____

Restrictions: _____

_____

If disabled, diagnosis in order of importance.

1) _____ 3) _____

2) _____ 4) _____

Medications Prescribed: _____

_____ _____

Physician Name / Signature **Date**