61 Locust Street, Suite 334
Dover, New Hampshire 03820-3704
(603) 516-6500
Dover-Publicwelfare@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 Signature _____ **Date** _____

_____ **Office name** _____
Physician's Name (please print Name)
_____ **Office phone** _____
_____ **Office fax** _____