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Medical Verification Form

Name: _____

Date of Birth: _____

Physician's Name: _____

Address: _____

I authorize the release of the following medical information to the City of Old Orchard Beach:

Signature: _____ Date: _____

State regulations require that persons receiving assistance work or participate in activities to prepare them for work unless they are physically or mentally incapable of working.

Below to be completed and signed by a licensed physician ONLY:

Specific Medical Problem(s) please be as detailed as possible:

Date individual was seen for medical condition(s): _____

Next appointment: _____

To what extent is the individual able to work or participate in activities to prepare for work (CIRCLE ONE- **Unable to determine/Able/Unable**)?

I am unable to make a determination. Reason:

The individual is able to work or participate in activities to prepare for work without restrictions:

Full time (40 hours/week)

Part time at _____ hours/week

The individual is able to work or participate in activities to prepare for work with restrictions:

Full time (40 hours/week)

Part time at _____ hours/week

Please list restrictions (i.e. sitting, standing, walking, climbing stairs/ladders, kneeling/squatting, bending, pushing/pulling, lifting/carrying):

The individual may participate in education/training programs:

Yes

No

The individual is unable to work or participate in activities to prepare for work at all:

The disability is permanent The disability isn't permanent and is expected to last _____ months

Definition of Disability under the Social Security Administration Standards: An individual who has a medically documented physical and/or mental health condition when prevents him/her from performing any type of work for at least one year. Would you advise this person to apply for permanent Social Security Disability benefits? Yes No

Would you recommend any form of rehabilitation for this individual (circle one)?

Vocational Rehabilitation Substance Abuse Mental Health Other