MEDICAL REPORT

COUNTY USE ONLY

Case name	Case number	Worker name	Worker number

SECTION I: PATIENT/CLIENT INFORMATION AND MEDICAL RELEASE

Name of patient/client (last, first, middle) / *Nombre del paciente/cliente (apellido, primer nombre, segundo nombre)*

Birth date / *Fecha de nacimiento*	Social Security number / *Número del Seguro Social*	Sex / *Sexo* ❒ Male/masculino ❒ Female/femenino	Ages of children in home / *Edades de los niños en el hogar*

I authorize / *Autorizo a* _____ of / *de* _____

Name of licensed physician or certified psychologist
Nombre del doctor con licencia o psicologo certificado

Name of clinic or medical group
Nombre de la clínica o grupo médico

to release my medical information on this form to the county welfare department. This authorization is valid for one year from the date signed and I may ask for a copy of this authorization.

al departamento de bienestar público del condado para que proporcione la información médica que se solicita en este formulario. Esta autorización es válida por un año a partir de la fecha de la firma y tengo derecho a solicitar una copia de esta autorización.

Patient/client signature / *Firma del paciente/cliente* ➤	Date/*Fecha*

SECTION II: PHYSICIAN OR LICENSED/CERTIFIED PSYCHOLOGIST INSTRUCTIONS AND CERTIFICATION

The county welfare department needs your information to determine if the above-named person has a physical or mental incapacity that prevents or substantially reduces the patient's ability to engage in full-time work, training, and/or provide necessary care for his/her child(ren).

Please complete the rest of this form. Explain if you need additional lab work or other exam(s) before you can determine the duration of incapacity. If you need more space, use another sheet of paper and attach it to this form.

PLEASE GIVE THIS FORM TO THE PATIENT OR RETURN IT AND/OR OTHER VERIFICATION WITHIN FIVE WORKING DAYS TO:

(County Stamp)

1. Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her ability to work full time at his/her customary job?
   - ❒ Yes If yes, expected duration: _____
     - ❒ Temporary, expect to release patient for full-time work on _____ (month, day, year)
     - ❒ Permanent
   - ❒ No
2. Does the patient have a physical or mental incapacity that prevents or substantially reduces his/her abililty to care for his/her children?
   - ❒ Yes If yes, expected duration: _____
     - ❒ Temporary, expect to release patient for full-time work on _____ (month, day, year)
     - ❒ Permanent
   - ❒ No
3. List DIAGNOSIS and PROGNOSIS for this patient:

   _____

   _____

   _____
4. Onset date: _____ (month, day, year)

- I understand that the statements I have made on this form are subject to verification and investigation for welfare fraud.
- I declare under penalty of perjury under the laws of the United States and the State of California that the information contained in this report is true, correct, and complete.

Signature of physician, licensed certified psychologist, or person authorized to complete form ➤	Date
Printed name and title/specialty	Phone number ( )

Street address *(mailing address, if different)*	City	State	ZIP code