FORM H

MUNICIPAL WELFARE DEPARTMENT
MEDICAL RELEASE AND REPORT

APPLICANT NAME/SS#: _____ dob: _____

I hereby request the release by a doctor, hospital or clinic to the Municipal Welfare Department, or its authorized representative, any information regarding my medical diagnosis, medical history, treatment plan or hospitalization. A photocopy of this signed release may be used in place of an original, in effect for six months from date of my signature below:

_____ _____

APPLICANT SIGNATURE **DATE**

TO THE PHYSICIAN OR CLINIC:

The person named above has indicated that he/she is currently unable to work and is in treatment with you. New Hampshire General Assistance laws require able-bodied welfare applicants to seek and retain work as a condition of continued assistance, with the goal of minimizing the period of assistance necessary. The Municipality also may require welfare recipients to work in any capacity that the recipient is able in exchange for assistance. For these reasons, will you please briefly respond to these questions:

What is the condition(s) for which you are treating this person? _____

What is the nature and extent of this individual's limitations? _____

Is this person disabled? No ❑ Yes ❑ (If yes, please clarify below)

❑ Temporarily ❑ Permanently ❑ Partially ❑ Totally

Date incapacity began: _____Expected to end: _____

When will this individual be capable of returning to work? What type of work would be suitable for this individual? Please describe any limitations: _____

_____

_____

Medications Prescribed: _____

_____ _____

Physician Name / Signature **Date**

Thank you for taking the time to complete this form.
Please contact the Municipal Welfare Department if you have any questions.