DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

RETURN TO: _____

_____

Name: _____ **Address:** _____

Major Complaint: _____

Usual Occupation: _____ **Date:** _____

MEDICAL CERTIFICATION

Dear Medical Professional:

The person named above has requested public assistance benefits or exemption from participation in employment and training activities. A medical certification is needed if the basis for the request is related to incapacity. Please assist us by responding to the following questions.

Sincerely,

_____

Staff Worker/Pool Code

1. Date of Examination:_____

   Diagnosis: _____

   If pregnant, EDC_____ and age of gestation _____

2. Is the patient's ability to support or care for his/her child(ren) substantially reduced and expected to last at least 30 days? ❑ Yes ❑ No ❑ N/A

3. Is the patient able to work at his/her usual occupation? ❑ Yes ❑ No

4. If the patient cannot perform his/her usual occupation, have you permitted or will you permit him/her to perform any other work on a full time basis? ❑ Yes ❑ No

5. If the patient is unable to work, what is the estimated duration of the illness? (Check One) ❑ 1 Month ❑ 2 Months ❑ 3 Months ❑ 4 Months ❑ 5 Months ❑ 6-12 Months ❑ More than 12 Months

6. Does the incapacity of the patient named above require the presence of another individual in the home to care for him/her? ❑ Yes ❑ No

7. Remarks, if any _____.

_____ _____

Medical Professionals Signature Date

Medical Professional's Name (Please Print): _____

Address: _____Telephone: _____

Patient's Signature: _____ Date: _____