



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/Team 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?
3. Is the patient able to work at his/her usual occupation?
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?
5. If the patient is unable to work, what is the estimated duration of the illness?
6. Does the incapacity of the patient named above require the presence of another individual in the home to care for him/her?
7. Remarks, if any

Medical Professional's Signature

Date

Medical Professional's Name (Please Print):

Address: Telephone:

Patient's Signature: Date: