90-250 APPENDIX A. FORM CSF 24

COUNTY OF SAN DIEGO

MEDICAL REPORT
VERIFICATION OF PHYSICAL/MENTAL INCAPACITY - GENERAL ASSISTANCE

Case Name: _____

Case Number: _____

Worker Name: _____

Worker Number: _____

Worker Telephone: _____

Date: _____

In order to be eligible for _____, employable adults must participate in a Work Project which may consist of gardening, maintenance work, or clerical duties throughout County facilities. Persons who are physically/mentally incapable of employment may be exempted from the Work Project if their incapacity is clearly documented and verified. When properly completed, this form may furnish the required documentary evidence.

I authorize the release of all information regarding my disability to _____ County.

Client's Signature: _____ Date: _____

Instructions to Physicians: The applicant named above states that she/he is physically or mentally incapacitated and unable to engage in basic work activities. This report should provide the Human Services Agency with an assessment of any medically verifiable condition(s) which would prevent or limit the applicant from accepting and/or keeping employment.

1. Is this person able to work at this time?

[ ] Can work
[ ] Can perform no work
[ ] Can perform limited full-time work
[ ] Can perform limited part-time work

2. Is the disability permanent?

[ ] Yes [ ] No

EMPLOYABLE WITH LIMITATIONS (WORK RESTRICTIONS):

	No Capacity	Partial Capacity	Full Capacity
Lifting, pushing, pulling 0-10 lbs			
Lifting, pushing, pulling 10-20 lbs			
Lifting, pushing, pulling 20-30 lbs			
Lifting, pushing, pulling 30-50 lbs			
Lifting, pushing, pulling >50 lbs			
Continuous Sitting			
Continuous Standing			
Overhead Work			
Squatting/Kneeling			
Minimal use of L or R Hand			

3. Has the patient submitted a disability insurance application for completion?

[ ] Yes Date _____ No [ ]

4. Does the medical condition of the patient permit any of the following work? (Please check yes or no to all three.)

Gardening/Maintenance [ ] Yes [ ] No
Restricted Work: Sedentary/Clerical [ ] Yes [ ] No
Patient can care for herself/himself? [ ]Yes [ ] No

5. If the patient is unable to work or seek gainful employment, or care for themselves at the present time, please estimate a date when the incapacity will end or require re-evaluation. _____
Through Date

6. Is the patient cooperating with prescribed medical treatment?

[ ] Yes [ ] No

Signature of Physician/Psychologist _____ Date: _____

Address: _____ Phone Number: _____