COMPASSIONATE APPEAL - ATTENDING PHYSICIAN'S STATEMENT
Appeal due to Extreme Sickness or Poverty under Section 357 (d.1) of the Municipal Act

Name of Patient **Age** xxx

1) PATIENT HISTORY

a) When did the symptoms first appear or the accident happen?

b) If applicable, when did the patient cease work because of disability?

2) PRESENT CONDITION

At this date is the patient:

a) ☐ **Ambulatory**
b) ☐ **Bedridden**
c) ☐ **Confined to House**
d) ☐ **Hospitalized**
e) ☐ **Other**

If "Other" Please Explain:

3) BRIEF DIAGNOSIS

4) EXTENT OF DISABILITY

Is the patient totally disabled?

☐ **No – Anticipated date for return to work:** _____
☐ **Yes**

In your opinion will the patient ever be able to resume any type of work?

☐ **No**
☐ **Yes If yes, give an approximate date:** _____

5) REMARKS

_____ _____
Signature of Attending Physician **Date**

_____ _____
Address **Telephone No.**

Note: Any charge for completing this form is the patient's responsibility.