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** _____

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.