First Nation Income Assistance Program
Medical Release and Assessment for Disability Benefits
Personal and Confidential

I, _____ of _____
(Person or Guardian) (Address)
authorize the release of medical information to _____
(Administering Authority)
in order to determine eligibility for disability benefits or other medical benefits.

_____ _____
(Signature of Person Issuing Release) (Date)

_____ _____
(Signature of Income Assistance Administrator) (Date)

TO BE COMPLETED BY EXAMINING PHYSICIAN OR PSYCHIATRIST:

Information Required to Determine Medical Eligibility:

Name of Patient: _____ Treaty Number: _____

Medical Condition:

_____

_____

Does this patient's condition impede their ability to work (are they disabled): _____ Yes _____ No
Does this patient require 24 hour care: _____ Yes _____ No

Is this condition permanent: _____ Yes _____ No
If "No", the expected duration of the condition:

_____

Other Medical Requirements:

_____

_____

Name and Address of Physician or Psychiatrist: _____
(Please print)

_____

_____

_____ _____
(Signature of Physician or Psychiatrist) (Date)

_____
(Title of Physician or Psychiatrist)

For Income Assistance Administrator Use Only:

Expiry Date of Medical Form: _____