

**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: \_\_\_\_\_