Iowa Department of Human Services

PHYSICIAN'S STATEMENT

Date: ________________

Payor: ____

Patient Name: (Print)____

Payor's Relationship to Patient: ____________________________

Case Number: __________

Child Support Recovery Unit

____

____

____

Tel.: ________________

Patient's Consent to Release of Information:

I authorize the release of the following information about my medical condition to the Department of Human Services, Child Support Recovery Unit (Unit).

Date: ______________ Signature of Patient: ______________________________________

____

Signature of Legal Guardian, if patient is a minor or is mentally incompetent

Return completed forms to the Unit at the address listed above.

* «C A S E N O»*

Iowa Department of Human Services

Physician's Statement

Date: ___________
Worker ID: ______

This form must be completed by a licensed health care practitioner. A licensed physician, licensed osteopath, licensed or certified psychologist, or licensed optometrist (if incapacity involves seriously impaired vision).

The Department of Human Services' Child Support Recovery Unit will use the information you provide to decide when __________ will be able to make payments on a child support obligation.

Complete This Section On Behalf of A Payor Who May Be Disabled

1. Based upon the medical history for __________ and your knowledge of the medical condition, does __________ have a physical or mental impairment that makes __________ incapable of performing the duties of the job for which __________ is suited by education, training, or experience? ❑ Yes ❑ No

If **yes**, __________ has been incapacitated since: ________________________

a. Is the incapacity permanent and will completely and permanently prevent __________ from working this type of job? ❑ Yes ❑ No

b. If the incapacity is not expected to be permanent, approximate date __________ should be able to work at any job for which __________ is reasonably suited by education, training, or experience:________________________________

c. If incapacity is due to pregnancy, what is expected delivery date:____________________

2. Based upon the patient's medical history and your knowledge of the medical condition, will ___________ be able to perform other types of jobs with appropriate education and training? (See examples) ❑ Yes ❑ No

Example: Person cannot lift items over 10 pounds may be able to work in a job with no or very little lifting.

Example: Person cannot sit for long periods of time may be able to work in a job where moving and standing are needed.

Example: Person cannot stand for long periods of time may be able to work in a job where sitting is needed.

Complete This Section On Behalf Of A Payor's Household Member Who May Be Disabled

3. Based upon the patient's medical history and your knowledge of the medical condition, does the patient need continuous in-home care that ___________ is required to be in the home to provide? ❑ Yes ❑ No

4. Based upon the patient's medical history and your knowledge of the medical condition, will the type of care or amount of care this patient needs prohibit ___________ from working or seeking any employment?
❑ Yes ❑ No

If **yes** to question 3 or question 4, what is expected date for ending the continuous in-home care that ___________ is required to provide? ___________________________

Physician Signature:____ Date:________________________

Physician Name: (Print)____ Phone:________________________

Address:____

Type of Practice/Medical Specialty: __________________________________ Degree:_____________________

Return this form to: Child Support Recovery Unit
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