Washington Township
1310 Horton St. Marion
Indiana 46952
Phone 765-573-5822
Tresa.Baker@washingtontownship.in

*** MEDICAL STATEMENT ***

Client Name: _____

SS#: _____

Address: _____

*** Disclosure Statement ***

I give permission for all the following to be released to Washington Township Trustee's Office

Signature of Client _____

Date _____

Medical Provider – Your client has requested to apply for Poor Relief financial assistance in Washington Township Trustee's Office. Eligibility standards for assistance require all able-bodied persons to be working or seeking work. The client has stated to this office that they are unable to work due to a physical or mental condition.

*** Please verify this statement by completing the following portion of this form. The form **MUST** be completed by the Medical Provider and then ***submitted DIRECTLY TO THE OFFICE*** *not through the client.* ***

Client/Patient Name: _____

The above named client is ABLE to work: YES NO

The above named client is able to work with the FOLLOWING INSTRUCTION: YES

_____

The above named client is NOT ABLE to work: from start date _____ to end date _____

The above named client is PERMANENTLY DISABLED as of _____

Reason unable to work: _____

Medical Provider Printed Name and Signature

_____

Address/Phone: _____

Date: _____

THIS FORM **MUST BE FAXED or EMAILED** from the Medical Provider to the Trustee's Office