National Housing Trust
...the key to your home

MEDICAL REPORT

THIS FORM IS INTENDED TO GIVE THE NATIONAL HOUSING TRUST AN UNDERSTANDING OF THE PATIENT'S MEDICAL CONDITION AND ITS IMPACT (IF ANY) ON HIS/HER ABILITY TO WORK.

INSTRUCTIONS TO DOCTOR:

1. OBTAIN PATIENT'S AUTHORIZATION TO RELEASE HIS/HER MEDICAL INFORMATION.
2. COMPLETE ALL SECTIONS OF THE FORM.
3. ENCLOSE IN AN ENVELOPE.
4. SEAL AND ADDRESS THE ENVELOPE TO :

The Manager
Loan Administration Unit
Loan Management Department
National Housing Trust
4 Park Boulevard
Kingston 5

N.B. NHT WILL NOT ACCEPT THE FORM IF IT IS NOT SUBMITTED IN A SEALED ENVELOPE .

SECTION A PATIENT DETAILS

1. PATIENT'S FULL NAME: _____ (LAST NAME) _____ (FIRST NAME) _____ (MIDDLE NAME)

2. PATIENT'S DATE OF BIRTH _____ (DD/MM/YY)

3. PATIENT'S STATED OCCUPATION _____

SECTION B DETAIL OF ILLNESS

4. DESCRIBE THE CIRCUMSTANCE OF THE ILLNESS/INJURY _____

5. DATE OF FIRST VISIT BY PATIENT REGARDING THIS ILLNESS/INJURY _____ (DD/MM/YY)

6. DIAGNOSIS _____ 7. DATE OF DIAGNOSIS _____ (DD/MM/YY)

8. CURRENT TREATMENT BEING UNDERTAKEN _____

9. ESTIMATED PERIOD OF TREATMENT: From _____ (DD/MM/YY) To _____ (DD/MM/YY)

10. STATE FUTURE TREATMENT REQUIRED _____

SECTION C ABILITY OF PATIENT TO WORK

11. CAN THE PATIENT WORK Yes ☐ No ☐

A.(i) IF YES, STATE HOW SOON THE PATIENT CAN RETURN TO WORK

IMMEDIATELY ☐ WITHIN 30 DAYS ☐ 31 TO 90 DAYS ☐ 91 TO 180 DAYS ☐ OTHER, Please state _____

(ii) CAN THE PATIENT WORK WITHOUT RESTRICTIONS OR LIMITATIONS Yes ☐ No ☐

IF NO, STATE THE LIMITATIONS OR RESTRICTIONS _____

STATE THE RECOMMENDED NUMBER OF WEEKLY HOURS THAT THE PATIENT IS ABLE TO WORK AND THE DURATION

WEEKLY HOURS (Assuming a 40 hour work week) _____ HOURS

PERIOD: From _____ (DD/MM/YY) To _____ (DD/MM/YY)

B. IF NO, (I.E. THE PERSON IS TOTALLY UNABLE TO WORK AT THIS TIME) DUE TO ILLNESS OR INJURY, PLEASE EXPLAIN BELOW:

STATE WHY: _____

PLEASE STATE THE ESTIMATED DATE WHEN THE PERSON WILL BE ABLE TO RETURN TO WORK

- PART TIME: _____ (DD/MM/YY) WEEKLY HOURS (Assuming a 40 hour work week) _____ HOURS
- FULL TIME: _____ (DD/MM/YY)
- UNABLE TO SAY, Please specify _____

SECTION D APPROVAL

I CERTIFY THAT THE ABOVE INFORMATION ACCURATELY REFLECTS MY KNOWLEDGE OF THE PATIENT'S CURRENT MEDICAL CONDITION.

Name of Doctor: _____ Area of Specilization: _____

Signature & Stamp _____ Date: _____ (DD/MM/YY)

Designed by: MSU/HRM Dept. April 2015.