

1249 Donald Lee Hollowell Parkway, NW

Atlanta, GA 30318-665

(404) 206-5721 FAX (404) 206-5630

Information Requested by: DCS

Medical Statement

Physician's Name: [Redacted]

Physician's Address: 2600 MLK JR DR SW STE 200 ATLANTA 30

Re: [Redacted]

Date of birth: 01-14-1961 Client ID: _____

The above named individual is an applicant/recipient of public assistance and is currently being evaluated for training and job placement. Part of the process is the development of an employment plan based on the client's health condition. Please, provide the following information for assessment of appropriate employment. (See reverse side for Release of Medical Information.)

Diagnosis of Illness: Type 2 diabetes mellitus with chronic kidney disease and retinopathy

Expected Duration of Illness: Lifelong

Is the patient still under your care for this illness? Yes No

In your opinion, is this patient able to work full time? Yes No

* If unable to work full time, please, complete the information on the back of this form.

If the individual may be employed, with limitations, please, list specific limitations: She will need a flexible part time secondary work schedule to allow her to be able to get to doctor's appts on a regular basis

Physician's Signature: [Redacted] Date: 4/24/07

Complete this Section if this Medical Statement is for a Caretaker

If unable to work at this time, when do you anticipate this patient will be able to return to employment?
_____ days _____ weeks _____ months

In your opinion, is this individual needed as a caretaker to provide regular care and maintenance for _____
_____ Yes _____ No

If needed to give daily assistance, could the caretaker maintain employment outside the home while providing care?

____ No, must provide constant care OR Caretaker may work: ___ Part-time ___ Full-time

Denied 3 times.