

Department of Human Resources and Employment
Employment and Career Services

MEDICAL REPORT

(To be attached to the application for Training Services under EAPD)

NAME: _____ FILE NO. _____

ADDRESS: _____

DATE OF BIRTH (y/m/d): _____

The applicant was seen by me on: _____
Date

1. The nature and extent of present disability is:

2. Present functional status (walking, use of hands, lifting, etc.) Describe physical limitations if any:

3. Other medical conditions not outlined above which may affect participation in training/employment:, if so explain:

Medical Doctor (Please Print Name)

Signature

Date