Date:	Participant's Name:	CIN Number:	OBWP:

Participation Ability Request Form

Diagnosis:	Date of Onset:
Condition expected to last _____ months from this date:_____	

It is our goal to assist the individual names above in preparing their transition from welfare to work. This person states that he/she has a physical/mental limitation and may be unable to perform tasks/work. Please give careful consideration in completing this medical evaluation. The information that you provide will be used to determine activities this individual may be able to participate in and duties he/she may be able to perform, even if there are some limitations.

Check all activities that the patient can presently participate in and fax completed form to:

CM Name:	CM FAX Number:	Deadline Date:

- ☐ Classroom-based work leading to GED, other certification or degree
- ☐ Educational activities that address job etiquette, job behaviors, social skills
- ☐ Vocational Rehabilitation (BVR, OSRC)
- ☐ Skills training in an occupation within patient's health-related limitations (i.e., basic computer class)
- ☐ Volunteer work/community service
- ☐ Job Searching (contacting employers online, via phone or in person)
- ☐ Comments:

Physician Signature	Specialty	Date
Physician Address		Physician Phone

My signature below authorizes the release of medical data to Hamilton County Job Family Services Collaborative.

Patient Signature (Parent/guardian signature if patient less than 18 years old):