Department of
Financial Assistance
Cayman Islands Government

Medical Form

This form is to be completed by a medical doctor or medical officer as per the Financial Assistance Act, 2022 and associated Regulations.

As per the Financial Assistance Act, 2022 –
medical doctor means a medical doctor registered under Schedule 4 of the Health Practice Act (2021 Revision).

medical officer means —

a) a psychiatrist registered under Schedule 4 of the Health Practice Act (2021 Revision); or

b) a clinical psychologist who is registered under Schedule 6 of the Health Practice Act (2021 Revision) and, in addition, has a doctoral qualification in that discipline from a country or institution referred to in regulation 6 of the Health Practice Regulations (2021 Revision),
and is employed by, or is allowed to use the medical facilities of, the Government, a statutory body or government company.

The purpose of this document is for a medical doctor or medical officer to inform the Department of Financial Assistance whether an individual is able to work, or if they have a temporary or permanent disability.

This form is to be submitted via email to **DFAMedical@gov.ky** by the medical officer or medical doctor.

The following section is to be completed by the applicant or recipient of financial assistance.

Application ID _____ **FAS ID** _____

Name of Household Member

First Name | Middle Name | Last Name

Date of Birth of Household Member dd/mm/yyyy

Physical Address of Household Member

House# | Street Name

Apt# | Bldg Name | Neighbourhood

Select your District

☐ Bodden Town ☐ West Bay ☐ East End ☐ George Town
☐ North Side ☐ Cayman Brac ☐ Little Cayman

I, _____ (household member) consent to the information on this form being provided to the Department of Financial Assistance.

_____ Signature

_____ Date

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The following section is to be completed by the medical doctor or medical officer based on their medical expertise.

As per the Financial Assistance Act, 2022 "person with a disability" means a person who is certified by a medical doctor or medical officer, as applicable, as having a short-term or long-term physical, mental, intellectual or sensory impairment which significantly hinders, or which may hinder, that person's full and effective participation in society, on an equal basis with other persons.

Name of Medical Doctor or Officer _____

Name of Medical Office or Organization _____

Does the client have a medical condition? ☐ Yes ☐ No

Does this individual have any special needs:

i) Special diet: ☐ Yes ☐ No

ii) Medication needed: ☐ Yes ☐ No

In your medical opinion, is this individual medically (Physically/Mentally/) fit for employment:

a. ☐ **PERMANENTLY UNFIT REASON:**

☐ Physical ☐ Mental

b. ☐ **TEMPORARILY UNFIT REASON AND PERIOD:**

i. ☐ Physical ☐ Mental

ii. ☐ 1 Week ☐ 2 Weeks ☐ Month ☐ 3 Months ☐ 6 Months ☐ 1 Year

Other, please specify:_____

c. ☐ **FIT FOR EMPLOYMENT, BUT WITH SOME MEDICAL LIMITATIONS REASON AND PERIOD:**

i. ☐ Physical ☐ Mental

ii. ☐ Limitations are temporary:

☐ 1 Week ☐ 2 Weeks ☐ 1 Month ☐ 3 Months ☐ 6 Months ☐ 1 Year

Other, please specify: _____

iii. ☐ Limitations are permanent

d. ☐ **FIT FOR EMPLOYMENT AND HAS NO MEDICAL LIMITATONS**

In your medical opinion or from client's medical records, is this individual currently in need of drug rehabilitation for any current use/abuse of any substance? ☐ Yes ☐ No ☐ Unknown

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What are the assessed impairments of the client?

What are the limitations to the client as a consequence of the impairments?

In your medical opinion, does this household member have difficulty making decisions? ☐ Yes ☐ No

If yes, what sorts of decisions do they have difficulty making?

In your medical opinion, is there a class of work that cannot be undertaken by the client? ☐ Yes (please specify below) ☐ No

I, _____ verify that the information contained within this form is accurate and complete to the best of my knowledge.

_____

Signature

_____

Date

Please stamp this page with a stamp from your organization as applicable.

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