Jackson County
General Assistance

Incapacity to Work Form

This form must be signed by a medical professional.

Applicant Information		
Full Name:		Birthdate:
Email:		Phone:
Address:	City:	Zip:

Office/Clinic Information			
Printed Name of Medical Professional:			
Name of Office/Clinic:		Phone:	
Address:	City:	State:	Zip:

The following section needs to be completed by the medical professional.

Disability Information	
Is the disability: ☐ Temporary (able to return to work) ☐ Permanent	
Date disability started: ____/____/_____	Temporary disability end date: ___/___/_____
Does the disability affect their ability to work? ☐ Yes ☐ No	
Are there work limitations to their disability? ☐ Yes ☐ No Explain:	

By signing this form, the medical professional verifies that all the above information is accurate and true.

Physician's Signature Date

By signing this form, the applicant releases medical information regarding their disability or inability to work.

Applicant's Signature Date

Medical provider fax back directly to Jackson County General Assistance

Fax# 563-652-0337 - Phone# 563-652-1743