Sample Medical Statement Form to document "Unfit for Work" under SNAP Time Limit Rules
Once filled out, return to your local SNAP office.

To be completed by patient
Patient Name ____
Address ____
____

I, _______________________________ request verification of my physical or mental condition or my participation in a drug and alcohol program.
(insert name)

To be completed by healthcare professional:

Does this patient have **a temporary or permanent mental and/or physical condition**, which restricts his or her ability to work 20 hours a week? __yes ___no

If **yes**, please indicate the **duration** of the patient's inability to work 20 hours or more a week due to this illness/disability:
____less than 30 days
____1-3 months
____3-6 months
____6 -9 months
____9-12 months
____more than 12 months/or indefinite

To be completed by staff/counselor at a Drug and Alcohol Program
I this person a participant in a drug and alcohol treatment or counseling program, which restricts his or her ability to work 20 hours a week? ___yes ___no

If yes, what is the anticipated program end date: ___________________________________

Signature and contact information for both health care professional and staff at a drug and alcohol program:
I certify that the information provided above is true and accurate.

________________________________ _____________________________ ___/_____/____________
Name (please print) Title/profession** Date form signed

____
Signature Address Phone

** This form may be signed by any of the following health care providers: physician, physician's assistant, representative of the physician's office, nurse, nurse practitioner, licensed or certified psychologist, or a social worker. It may also be signed by a counselor or staff person at a drug and alcohol program.