An Roinn Coimirce Sóisialaí
Department of Social Protection

Confidential Medical & Functional Capacity Report (WSS DCMA)

CONFIRMING DISABILITY FOR ELIGIBILITY FOR WAGE SUBSIDY SCHEME
(WHEN THE APPLICANT IS NOT ON A QUALIFYING DSP DISABILITY PAYMENT AND PROFESSIONAL MEDICAL CONFIRMATION OF DISABILITY IS REQUIRED IN ORDER TO PROCESS THE APPLICATION.)

Name: _____ Date of Birth: _____

Address: _____

_____

PPS No: _____ My patient since: _____

Medical Details

Does this person have a **disability*** or a long-term **medical condition/s?**

Yes ☐ No ☐

*A physical, learning or mental health difficulty, which has a substantial and adverse effect on the person's ability to carry out day to day activities. (In this context, substantial means not minor and long-term means expected to last at least a year). The definition of disability is as contained in the Disability Act, 2005.

If yes, please describe: _____

_____

When did the condition(s) that led to the reduction of work capacity start? _____

_____

How long do you expect the condition(s) to continue? _____

_____

Please give details of any ongoing and/or anticipated medical/surgical interventions:

_____

_____

Does your patient take medication?

Yes ☐ No ☐

What side effects (if any) does your patient experience? _____

_____

Functional Assessment

Mental Health				
	Normal	Mildly Impaired	Moderately Impaired	Severely Impaired
Coping with ADL				
Completion of tasks				
Coping with change/pressure				
Interaction with others				

Physical Health (Impairment Scale)					
	Normal	Mild	Moderate	Severe	Profound
Hearing (R/L)					
Vision (R/L)					
Dexterity (R/L)					
Shoulders					
Arms					
Hands					
Fingers					
Mobility					
Walking					
Static standing					
Dynamic standing					
Sitting					
Ability to use public transport					
Agility					
Balance					
Climbing stairs					
Stooping/bending					
Strength					
Push and pull					
Lift and carry					

Comments:

_____

_____

Occupational Details

Is this person fit to work at least 15 hours per week?

Yes ☐ No ☐

Proposed employment: _____

Do you consider that this person's disability or medical condition(s) is causing or could cause him/her to have a shortfall in productivity in the proposed employment in comparison to a colleague without a disability or medical condition(s)?

Yes ☐ No ☐

Please give any additional information that may assist this application:

In my opinion, this person has _____

_____

_____

_____

Name of Doctor/Specialist: _____

Signature of Doctor/Specialist: _____

IMC No: _____

Address: _____

_____

_____

Date: _____

Official Stamp of Doctor/Specialist

Please return the completed form to your patient.

Thank you for your assistance.