



DEPARTMENT OF EMPLOYMENT, TRAINING AND REHABILITATION
 Employment Security Division
MEDICAL STATEMENT

To:

Date:

Please Respond By:

SSN: _____

To Claimant: Please take this form to your physician for completion and return it as soon as possible. Failure to provide the required information by the date shown could result in a delay or denial of unemployment benefits.

To Physician: Please provide the medical information requested below needed to determine the claimant's eligibility for unemployment benefits. Please complete all fields. We appreciate your cooperation in this matter.

Patient's Name:

1. Dates patient was under my care- From: _____ To: _____

2. Nature of illness or disability
please use layman terms: _____

3. Date illness or disability occurred: _____

4. Was patient hospitalized for treatment of an emergency or life-threatening condition? Yes No N/A

5. Did you advise the patient to quit his or her job for health reasons? Yes No N/A

5a. If "Yes", Please provide the date the claimant was so advised: _____

6. Did you advise the claimant to quit his/her job due to a family member's medical problem? Yes No N/A

6a. If "Yes", please provide the date that claimant was so advised: _____

7. Did you advise the claimant to relocate for medical reasons? Yes No N/A

7a. If "Yes", please provide the date claimant was so advised: _____

8. Did you advise claimant to relocate due to medical problems of a family member? Yes No N/A

8a. If "Yes", please provide the date claimant was so advised: _____

9. If the patient is the claimant, has he/she been unable to work while under your care? Yes No N/A

9a. If "Yes", please provide the dates unable to work: From: _____ To: _____

10. If the patient is the claimant, is he/she released to return to work in the following jobs?

Primary Occupation: Yes No N/A

Secondary Occupation: Yes No N/A

Date released for work, or, if not currently released, anticipated release date: _____

11. Please describe any work limitations the patient may have relative to the occupation (s) shown

12. If claimant is under your care due to pregnancy, please provide the expected delivery date: _____

13. Is claimant needed to provide ongoing care for the health of a family member? Yes No N/A

14. Other information:

Please Return this form to:

Nevada Employment Security Division

UI Operation Center North UI Operation Center South
 500 E. 3rd St. PO Box 43147
 Carson City, NV 89713 Las Vegas, NV 89116
 FAX (775) 684-0338 FAX (702) 486-7987

Physician's Signature _____
 Printed Name, Address and Phone : (Rubber Stamp OK)

