UTAH DEPT OF WORKFORCE SERVICES
UI DIVISION
140 EAST 300 SOUTH
PO BOX 45266
SALT LAKE CITY, UT 84145-0266

Utah Department of Workforce Services
Unemployment Insurance
Medical Report

First Name: _____

Last Name: _____

Date of Birth: _____

Please have your heath care provider complete this form within 10 days. If this form is not returned within 10 days**,** then a decision will be made using the best available information.

RETURN TO: Utah Department of Workforce Services, P.O. Box 45266, Salt Lake City, UT 84145-0266, Phone 801-526-4400 or Fax 801-526-4402. Please do not send a cover sheet.

I authorize release of medical information to determine eligibility for unemployment benefits. I understand information provided may be released to my former employer.

YOUR HEALTH CARE PROVIDER MUST COMPLETE THIS FORM

Claimant Signature _____ Date _____

1. Diagnosis (in lay terms) of this individual's illness, injury, or disability:

   _____

2. Date of first examination _____ Most recent examination _____
3. During your treatment of the condition, did you advise the patient to:
   a. Take time off from work? [ ] Yes [ ] No If yes, date advised _____
   b. Change occupations? [ ] Yes [ ] No If yes, date advised _____
   c. Change employers? [ ] Yes [ ] No If yes, date advised _____
   d. Discontinue working? [ ] Yes [ ] No If yes, date advised _____
4. Was the patient hospitalized? [ ] Yes [ ] No If yes, give dates: From _____ Through _____
5. How long was the patient unable to work 40 hours per week? Beginning _____ Ending _____
6. If patient was released for light duty only, please explain limitations: _____

   _____

_____
Name of Health Care Provider (print or type) Telephone

_____
(Address)

_____
(Title)

_____
Signature of Health Care Provider Date

DO NOT WRITE BELOW THIS LINE