

UTAH DEPARTMENT OF WORKFORCE SERVICES

Unemployment Insurance

**MEDICAL REPORT**

Name \_\_\_\_\_ SS # \_\_\_\_\_

**PHYSICIAN MUST COMPLETE THIS FORM**

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

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 patient hospitalized? Yes No If "Yes" give dates From \_\_\_\_\_ Through \_\_\_\_\_

5. How long was patient unable to work 40 hours per week? From \_\_\_\_\_ Through \_\_\_\_\_

6. If patient was released for light duty only, please explain limitations: \_\_\_\_\_

\_\_\_\_\_

RETURN TO:

WORKFORCE SERVICES  
CLAIMS CENTER  
PO BOX 45266  
SALT LAKE CITY UT 84145-0266  
FAX (801) 526-4402

\_\_\_\_\_  
Name of Physician (print or type) Telephone

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
Signature of Physician Date