

SOUTH DAKOTA DEPARTMENT OF LABOR
UNEMPLOYMENT INSURANCE DIVISION
MEDICAL STATEMENT OF ABILITY TO WORK

LOCAL OFFICE ONLY
What source generated this
form? _____
(202, 225, 203, etc.)

PREGNANCY

PATIENT'S NAME _____ SS No. _____

Date of Birth _____. I most recently worked for _____
(company name)
as _____. I feel I can work and will be seeking work in the following occupations(s)
(occupation)

CLAIMANT'S RELEASE: I herewith consent to the release of the below information to the Unemployment Insurance Division of South Dakota with the understanding that it is for the confidential use of that agency in determining my eligibility for unemployment insurance benefits.

Claimant's Signature Date

TO THE PHYSICIAN: The person named above has applied for unemployment insurance benefits. The information requested below will enable the Department to make a determination. Your cooperation in providing this information is appreciated. This information may be made available to the claimant. When completing this form, please refer to above data. (Our office is not responsible for any fees for completing this document.)

1. Patient is now pregnant: () Yes () No

If yes, her date of delivery will be about _____
If no, pregnancy terminated on _____

2. Would continued employment in her most recent employment have been a health hazard to her? () Yes () No

Did you advise her continued employment was hazardous? () Yes No ()
If yes, on what date? _____

3. At the present time, is she able to work in her most recent occupation? () Yes () No

If yes, as of what date? _____
If no, is she able to work in the other occupations listed above? () Yes () No
If yes, as of what date? _____

4. Describe any limitations on her present ability to work

Date Physician's Signature Degree

Please return this form within 7 days to:

Physician's Name _____
Business Address _____
Telephone () _____
If clarification is needed, who may we contact in your office?

ANY ALTERATIONS MUST BE INITIALED BY THE PHYSICIAN