

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.)

ACCIDENT OR ILLNESS

CLAIMANT'S NAME _____ SS NO. _____

Date of Birth: _____. I most recently worked for _____
(company name)

as _____. I have been under doctors care for _____
(occupation)

_____. I feel I could work and will be seeking work in the
(illness or injury)
following occupation(s): _____

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

PHYSICIAN: The person named above has applied for unemployment insurance benefits. The information requested below will enable the Department to make a determination on eligibility. Your cooperation in providing this information will be appreciated. This information may be made available to the claimant. Please refer to the above data when making your responses. (Our office is not responsible for any fees for completing this document.)

1. Date this illness or injury began _____
a. Date first examined or treated for this illness/injury _____
b. Date of last examination or treatment _____
2. Nature of this illness or injury (please use lay terms) _____
3. Would continued employment in the claimant's most recent employment have been a hazard to the claimant's health? ()Yes ()No
a. Did you advise this claimant continued employment would be hazardous? ()Yes ()No
If yes, on what date? _____
4. Describe any limitations on the claimant's present ability to work: _____
5. As of what date is/was the claimant able to work:
a. In his/her usual occupation? Date _____
b. In other occupations listed above if not in his/her usual occupation?
Date _____
6. If the claimant is not able to work at present, when will claimant probably be able to resume work? Date _____
7. Have you completed social security disability forms on behalf of this claimant?
()Yes ()No
a. If yes, on what date did the disability begin? Date _____
(Please provide this office with copies of the medical records submitted to the Social Security Administration.)
8. Comments: _____

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