

EMPLOYER RESPONSE—MEDICAL SEPARATION

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE.

Date: _____
Time: _____

Claimant Name: INTERSTATE CLAIMS IDAHO DEPARTMENT OF LABOR 155 N. MAPLE P.O. BOX 9 BLACKFOOT ID 83221-0009 208-785-5036 (FAX)	SSN: Employer Name, Address, Phone & Fax
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Paid or to be paid:

Gross earnings for the past 12 months \$	Severance: \$	On (date):
Vacation: \$	Bonus: \$	On (date):
Date payment will be received:	Holiday: \$	On (date):
Rate of Pay per hour: \$	Pension or Retirement pay was paid or will be paid:	
	\$	On (date):

Supervisor's Name:	Employer's Phone#:
Start Date of Employment:	Last Day worked:

Date of Separation: _____

Do you have a leave policy for employees who are unable to work? Yes (Please provide copy) No

Did the claimant discuss the possibility of a leave with you? Yes No

Briefly explain your leave policy.

Are you holding the claimant's job for him/her? Yes No

If the claimant is on a leave beginning date _____ ending date _____

Did claimant discuss the possibility of other work with you? Yes No

Do you have other work, which would accommodate the claimant's limitations? Yes No

Position: _____ Hours per day: _____ Rate of Pay: _____

If yes, did you offer this work to the claimant? Yes No If not, why not?

Did the claimant provide you with verifiable information (Medical statement—visual observation) of his/her ability to work? Yes No Explain: _____

Please provide any additional information you believe should be considered in determining claimant's eligibility.
NOTE: PLEASE ATTACH ANY RELATED DOCUMENTATION TO SUPPORT YOUR POSITION
For example written warnings, policy manuals, time cards, personnel records, statements from first-hand witnesses, written customer complaints, police reports, and other evidence to support your statement(s)

Employer/Employer's Representative Signature: _____

Print Name: _____ Title: _____

Phone Number: _____ Date: _____