CENTRAL OFFICE

FAX

IDAHO
DEPARTMENT OF LABOR
C.L. "BUTCH" OTTER, GOVERNOR
PAUL J. SPANNKNEBEL, INTERIM DIRECTOR

Date:

To:

Fax number: **(208) 639-3255**

Total pages:

From:

E-mail:

Phone number:

☐ **URGENT** ☐ **REPLY ASAP** ☐ **PLEASE COMMENT** ☐ **PLEASE REVIEW** ☐ **FYI**

COMMENTS:

IDAHO
DEPARTMENT OF LABOR
C.L. "BUTCH" OTTER, GOVERNOR
PAUL J. SPANNKNEBEL, INTERIM DIRECTOR

UNEMPLOYMENT INSURANCE
MEDICAL REPORT

NAME: _____ SSN: _____ DATE: _____

I authorize release of medical information necessary to determine my eligibility for unemployment insurance benefits.

Claimant Signature_____ Date _____

To the Physician: The Idaho Employment Security law requires that an individual be able to work to qualify for unemployment insurance benefits. We request your opinion of this individual's physical or mental ability to work. **This is not an authorization for Idaho Department of Labor to become responsible on the claimant's patient account with your office. All charges are the responsibility of the claimant.**

1. Was there a time period where the patient was unable to perform any type of work, no matter how restricted (hours worked, job duties, etc)? Yes ☐ No ☐ If "Yes," give dates From _____ Through _____
2. What is the nature of the patient's illness, injury, or disability **(please use lay terms)** _____

   _____
3. Date of illness or injury _____ Date of first examination _____
4. Was patient hospitalized? Yes ☐ No ☐ If "Yes," give dates From _____ Through _____
5. During your treatment of the condition, did you advise the patient to:
   a. Take time off from his/her current employment?
      Yes ☐ No ☐ If "Yes", dates: From _____ Through _____
   b. Change occupations? Yes ☐ No ☐
   c. Discontinue working in any occupation? Yes ☐ No ☐

   If answered "Yes," to any of above please give date patient was so advised_____
6. Can the patient work **full-time** (40 hours per week)? Yes ☐ No ☐

   If answered "No," will the patient ever be able to return to **full-time** work? Yes ☐ No ☐

   If answered "Yes," date patient will be released to return to **full-time** work_____

   If answered "No," how many hours specifically can the claimant work (no range)_____

_____
Name of Physician Telephone

_____
Address

_____
Signature of Physician Date

Please fax this form to the Department of Labor at (208) 639-3255.

I-77-541
R. 05/14