

Name	Social Security Number*
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TO THE PHYSICIAN:

As the examining physician of the above-named individual, we appreciate your certification of your findings by answering the following questions:

1. Nature of medical condition, illness or disability (lay terms).		
2. Date medical condition, illness or disability occurred		
3. Patient under my care		
From	To	
4. Date last examined		
5. Did you advise the patient to quit their employment or remain away from their employment because of the above medical condition? If advised to remain away from employment, for what period of time? Start -	Until -	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the patient been unable to work at any time due to the above medical condition? If yes, give dates: From	To	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has the patient been released to resume employment? If yes, on what date?		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. If patient must now restrict the type of work, days or hours per week of employment, or place of work, please explain the limitation(s).		
Name of Physician	<p><u>CLAIMANT'S RELEASE</u> I herewith consent to the release of the above information to Job Service North Dakota with the understanding that it is for the confidential use of that agency in determining my eligibility for unemployment insurance benefits.</p>	
Name of Facility		
City, State, Zip		
Phone Number		
Physician's Signature		
Date	Claimant's Signature	
Date	Date	

Mail to:
UNEMPLOYMENT INSURANCE/CLAIMS CENTER
PO BOX 5507
BISMARCK, ND 58506-5507

Fax to:
701-328-2728

*In compliance with the Privacy Act of 1974, a Social Security Number is mandatory on this form pursuant to 20 CFR 666.150 and/or North Dakota Century Code 52-02-02. This number is used by Job Service North Dakota for identification, federal and state tax, program eligibility purposes and program performance accountability.