MEDICAL STATEMENT

JSND/UNEMPLOYMENT INSURANCE
SFN 41254 (R. 10-11)

Please fill out, print and return to Job Service North Dakota

Name	Social Security Number*

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 -	☐ Yes	☐ No
6. Has the patient been unable to work at any time due to the above medical condition? If yes, give dates: From To	☐ Yes	☐ No
7. Has the patient been released to resume employment? If yes, on what date?	☐ Yes	☐ 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	**CLAIMANT'S RELEASE** 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.
Name of Facility	
City, State, Zip	
Phone Number	
Physician's Signature	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.