

MAINE DEPARTMENT OF LABOR
Bureau of Unemployment Compensation

Mail To: (Choose one of the three addresses below for Unemployment Claims)			Telephone 1-800-593-7660
Unemployment Claims Center 97 State House Station Augusta, ME 04333-0097	Unemployment Claims Center P.O. Box 450 Bangor, ME 04402-0450	Unemployment Claims Center P.O. Box 1088 Presque Isle, ME 04769-1088	TTY Users Call Maine Relay 711

Name: _____ Soc. Sec. No. _____ Local Office: _____

Date Mailed: _____ Benefit Year : _____

MEDICAL INFORMATION

Medical information is needed to determine your eligibility for unemployment compensation benefits. Sign the release allowing your physician to provide the information. Give the form to your physician to complete and mail.
YOU ARE RESPONSIBLE FOR HAVING THIS INFORMATION SENT TO US.

I hereby authorize the release of my medical information for the purpose of determining my eligibility for unemployment compensation.

Signature	Date
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1. Name of practice _____
2. Name of physician _____
3. Nature of illness or disability _____
4. A. First date treated _____ B. Last date treated _____
5. Did you advise claimant to leave work? YES NO
If "YES," when did you advise him/her to leave work? _____
If "NO," was separation from work justified for medical reasons? YES NO
6. Is the claimant currently able to work full-time? YES NO
If "YES," when was claimant able to resume work? _____
If "NO," is claimant able to work part-time? YES NO
If "YES," as of when? _____ How many hours/days a week? _____
7. If claimant cannot return to work now, estimate when claimant can return to:
Regular Occupation _____ Other Occupation _____
8. Note any restrictions on claimant's work activities _____

9. From a medical point of view, the most recent work:
 - Had no effect on the claimant's condition
 - Aggravated the claimant's condition
 - Caused the claimant's condition
10. Remarks: _____

Physician's Signature	Physician's Telephone No.	Date
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