MAINE DEPARTMENT OF LABOR

Bureau of Unemployment Compensation

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| **Mail To:** Unemployment Claims Center  97 State House Station  Augusta, ME 04333-0097 | Telephone: 1-800-593-7660  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 |

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 |

Me. BD-4.7 (Web) (rev. 03/2019) **ATTACH ADDITIONAL SHEETS IF NEEDED**