MAINE DEPARTMENT OF LABOR
Bureau of Unemployment Compensation

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

ATTACH ADDITIONAL SHEETS IF NEEDED