

Appendices

Appendix Q: Health Care Providers' Statements



HEALTH CARE PROVIDER'S STATEMENT OF CAPABILITY									
ALL INFORMATION REQUESTED IN THIS FORM IS TO BE USED SOLELY IN DETERMINING THE VALIDITY OF A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS FILED WITH THIS DEPARTMENT ON _____ BY THIS CLAIMANT.									
All information transmitted to the Division of Unemployment Assistance relating to this worker shall be absolutely privileged and shall not be subject matter in any action of slander or libel in any court of the Commonwealth of Massachusetts.									
G. L. Chapter 151A, Section 46 (a)									
NAME	S.S.A. NO. <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>								
ADDRESS									
1. HAVE YOU TREATED THE ABOVE-NAMED CLAIMANT SINCE _____ ?..... <input type="checkbox"/> YES <input type="checkbox"/> NO									
2. APPROXIMATE PERIOD OF TREATMENTS? FROM: _____ TO: _____									
3. IN YOUR OPINION, DID CLAIMANT'S ILLNESS REQUIRE SUSPENSION OF WORK?..... <input type="checkbox"/> YES <input type="checkbox"/> NO									
ON WHAT DATE? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 40px; height: 20px;">MONTH</td><td style="width: 40px; height: 20px;">DAY</td><td style="width: 40px; height: 20px;">YEAR</td></tr></table>		MONTH	DAY	YEAR					
MONTH	DAY	YEAR							
4. WHAT WAS THE NATURE OF CLAIMANT'S ILLNESS AT THAT TIME?									
5. WAS CLAIMANT ABLE TO DO SOME TYPE OF FULL-TIME WORK ON ?..... <input type="checkbox"/> YES <input type="checkbox"/> NO									
6. DO YOU CONSIDER CLAIMANT NOW ABLE TO WORK AT REGULAR OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO									
7. IF NOT, IS CLAIMANT NOW PHYSICALLY ABLE TO DO SOME OTHER TYPE OF FULL-TIME WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO									
8. IF NOT ABLE TO PERFORM SOME TYPE OF FULL-TIME WORK, IS THE CLAIMANT CAPABLE OF PERFORMING PART-TIME WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO									
9. IF YOU ANSWERED YES TO QUESTION 8, WHAT IS THE EXPECTED DURATION OF THE CLAIMANT'S LIMITATION TO PART-TIME WORK? _____ WEEKS _____ MONTHS _____ INDEFINITELY									
10. ON WHAT DATE WAS CLAIMANT FIRST ABLE TO ACCEPT FULL-TIME WORK OF SOME NATURE? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 40px; height: 20px;">MONTH</td><td style="width: 40px; height: 20px;">DAY</td><td style="width: 40px; height: 20px;">YEAR</td></tr></table>		MONTH	DAY	YEAR					
MONTH	DAY	YEAR							
11. IF CLAIMANT IS PREGNANT, WHAT IS THE EXPECTED DATE OF DELIVERY? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 40px; height: 20px;">MONTH</td><td style="width: 40px; height: 20px;">DAY</td><td style="width: 40px; height: 20px;">YEAR</td></tr></table>		MONTH	DAY	YEAR					
MONTH	DAY	YEAR							
12.									
13.									
REMARKS:									
DATE ISSUED:									
THIS STATEMENT MUST BE SIGNED PERSONALLY BY THE PROVIDER									
I AM A DULY LICENSED HEALTHCARE PROVIDER IN THE STATE OF:									
SIGNED:	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 5px;">RETURN THIS FORM TO:</td> </tr> <tr> <td style="padding: 5px;"> </td> </tr> <tr> <td style="padding: 5px;">Attention:</td> </tr> </table>	RETURN THIS FORM TO:		Attention:					
RETURN THIS FORM TO:									
Attention:									
ADDRESS:									
DATE OF THIS STATEMENT:									

Appendices

A disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual.

An impairment is:

- a physiological disorder affecting one or more of a number of body systems
- or**
- a mental disorder
- or**
- a psychological disorder

Major life activities means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.

Substantially limiting means that the impairment:

- prohibits or significantly restricts an individual's ability to perform a major life activity as compared to the ability of the average person in the general population to perform the same activity
- or**
- limits an individual's ability to work if it prevents or significantly restricts the individual from performing a class of jobs or a broad range of jobs in various classes

Temporary conditions that last for only a few days or weeks with no long-term effects, such as influenza, sprain, and broken limbs, are not considered substantially limiting impairments. An impairment which is chronic, permanent, long-term (at least several months), potentially long-term, or leaves a permanent effect is a disability if it significantly restricts a major life activity. Also, an impairment which is expected to take significantly longer than normal to heal (e.g., a broken limb requiring a healing period of one year), may be a disability.