Appendix Q: Health Care Provider Statement

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

103827694

CLAIMANT ID:

CLAIM ID:
December 22, 2016

Health Care Provider's Statement of Capability

The Healthcare Provider's Statement of Capability is a required statement only if you have indicated you are not capable of working during weekly certification. Failure to return a completed form to the Department of Unemployment Assistance (DUA) for consideration by your deadline may result in disqualification. This document should be completed by a licensed physician or medical practitioner who is either familiar with the patient's condition, or has reviewed the patient's medical records. Once completed, patient is responsible for returning this form to DUA by 1/3/2017.

Patient's Name:_____ Patient's Address:_____

Date you began treating patient: _____ Date you last saw patient: _____

What is the nature of the condition you are treating the patient for?

_____

Has the patient been able (or capable) to work since 11/27/2016: (Check Box) Y ☐ N ☐

Is the patient currently able to work in a full-time capacity with no restrictions? (Check Box) Y ☐ N ☐

If yes, when did the patient become able to return to work full-time? _____

If no, on what date did the patient become unable to work full-time? _____

If no, list why the patient cannot work full-time without restrictions, or, if the patient can work with restrictions, explain the restrictions.

_____

Is the patient currently able to work in a part-time capacity with no restrictions? (Check Box) Y ☐ N ☐

If no, list why the patient cannot work part-time or explain what restrictions the patient has in his/her ability to work in a part-time capacity?

_____

If the patient is unable to work, when do you anticipate the patient will be able to return to work?

_____

If the patient is pregnant, what is the expected date of delivery? _____

Please list any other information regarding the patient's capability to work full-time:

_____

_____

_____

THIS STATEMENT MUST BE SIGNED PERSONALLY BY THE HEALTHCARE PROVIDER

I am a duly licensed physician/practitioner in the State of:_____

Name of physician/practitioner:_____

Signature:_____

Address:_____

Date of Statement:_____ Contact Phone Number:_____

Notice/Disclaimer

The information you provide will be used by the Department of Unemployment Assistance solely to determine whether the named individual is capable of performing suitable work, a condition of eligibility for unemployment benefits.

Patient is responsible for returning this form to DUA by 1/3/2017.

RETURN THIS FORM:

You can upload the completed form by logging in to your MA DUA account at www.mass.gov/dua. Go to your "Home Page", "View and Maintain Account Information" and select "Monetary and Issue Summary".
Select the Issue Identification Number 0020 4884 39-01 and use the Upload button available to upload supporting documentation.

Or mail it to:

Department of Unemployment Assistance
Central Document Processing Unit
19 Staniford Street
Boston, MA 02114