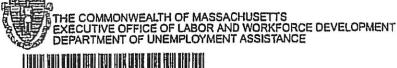
Appendix Q: Health Care Provider Statement





CLAIMANT ID>

CLAIM ID: December 22, 2016

Health Care Provider's Statement of Capability

The Healthcare Provider's Statement of Capability is a <u>required</u> statement only if you have indicated you are <u>not</u> 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

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 physicia	n/practitioner in the State of:
Name of physician/practition	ler:
Signature:	
Address:	ann an gu dha a bha a ban bail a gu a gu a bhainn ann an ann an an an an an an an an an
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

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