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HELP

SD EForm - 0783 V3

DLR-203-M Rev. 09/12

SD DEPARTMENT OF LABOR AND REGULATION
UNEMPLOYMENT INSURANCE DIVISION
PO BOX 4730
ABERDEEN, SD 57402-4730
FAX: 605.626.3172

MEDICAL STATEMENT OF ABILITY TO WORK

XNAME_____ DOB: _____ Last 4 digits of SSN:_____

XI most recently worked for_____ Xas a_____

XI have recently been under doctor's care for: _____

XMy physician is: _____

I ☐ am ☐ am not able to work at this time. I feel I am physically able to work and will be seeking work in the following occupation(s):

RELEASE OF INFORMATION: I hereby consent with my signature below to the release of information from my doctor or medical provider to the Unemployment Insurance Division for the confidential use of that agency in determining my eligibility for Unemployment Insurance benefits.

X_____ X_____

(Claimant's Signature) (Date)

CLAIMANT: Give this form to your physician to complete. Any alterations or changes to the information below must be initialed by your physician or may void this document.

PHYSICIAN: PLEASE COMPLETE THIS SECTION

The individual named above has applied for Unemployment Insurance benefits. The information requested below will enable the Unemployment Insurance Division to make a determination of the claimant's eligibility for benefits. Your cooperation in providing this information will be appreciated. This information may be provided to the patient/claimant. (Please note: our office is not responsible for any fees or charges for completing this document.)

1. Nature of **CONDITION, ILLNESS OR INJURY**:_____ date began:_____ .
2. On what date did you first examine this individual for this condition/illness/injury?_____
3. Date of most recent examination for this condition/illness/injury:_____
4. Would continued employment in the most recent employment listed above have been a hazard to this individual's health? ☐ Yes ☐ No
5. Did you advise this individual that this employment was a health hazard, or that he/she should leave this employment? ☐ Yes ☐ No If yes, when did you advise this individual that the employment was a health hazard?_____.
6. At the present time is this individual physically able to work in the occupation(s) listed above? ☐ Yes ☐ No
7. Date was or will be physically able to do this work:_____.
8. Please describe restrictions/limitations to claimant's present ability to work: _____
_____.
9. Comments:_____.

_____ _____ _____

Physician's Signature Degree/Title Today's Date

Physician's Name _____

Clinic Name _____

Address _____

Telephone _____ **FAX #** _____

If clarification is needed regarding your responses on this form, who should we contact in your office?_____.

Please FAX or MAIL this completed form within the next five (5) days to the address at the top of the form. Thank you for your assistance.

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