



MEDICAL STATEMENT
 JSND/UNEMPLOYMENT INSURANCE
 SFN 41254 (R. 12-04) TTY 800-366-6888

Check our Web Page at
www.jobsnd.com

Name	Social Security Number*
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TO THE PHYSICIAN:

As the examining physician of the above-named individual, we appreciate your certification of the results of your examination through your answers to the questions below.

1. Nature of illness of disability (lay terms).		
2. Patient under my care	From	To
3. Date illness or disability occurred		
4. Date last examined		
5. If condition due to pregnancy:		
a. What is the expected date of confinement?		
b. What was the date of childbirth?		
6. Did you advise patient to quit his/her last job because of illness, disability, or pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has patient been unable to work at any time due to illness, disability, or pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, give dates:	From	to
8. Has patient been released as able to resume employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, on what date?		
9. If patient must now limit the kind, days or hours per week, or place of work because of his/her health, please explain limitation.		
Date	Signature of Physician	
	Address	
	City, State, ZIP Code	
RETURN TO: JOB SERVICE NORTH DAKOTA UNEMPLOYMENT INSURANCE CLAIMS CENTER PO BOX 5507 BISMARCK ND 58506-5507 -OR- FAX TO: 701-328-2728	<u>CLAIMANT'S RELEASE</u> I herewith consent to the release of the above information to Job Service North Dakota with the understanding that it is for the confidential use of that agency in determining my eligibility for unemployment insurance benefits.	
(Local Office Address)	Claimant's Signature	

*In compliance with the Privacy Act of 1974, a Social Security Number is mandatory on this form pursuant to 20 CFR 666.150 and/or North Dakota Century Code 52-02-02. This number is used by Job Service North Dakota for identification, federal and state tax, program eligibility purposes and program performance accountability.