

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Unemployment Insurance Program

REPORT OF ILLNESS OR PHYSICAL DISABILITY

CLAIMANT'S NAME _____ SOC. SEC. NO. _____
(Last, First, M.I.)

PATIENT'S NAME _____
(Last, First, M.I.)

CLAIMANT'S PRIMARY OCCUPATION _____

Yes No Is the claimant the patient?

STATEMENT OF AUTHORIZATION: I authorize you to release the information requested below to the Department of Economic Security with the understanding that it will be used to make a determination of eligibility for unemployment insurance benefits.

CLAIMANT'S SIGNATURE _____ DATE _____

SECTION I TO BE COMPLETED BY PHYSICIAN

Mr.

Mrs. _____ has been most recently under my care for:

_____ From _____ to _____
(Nature of Illness) (Date) (Date)

IF THE CLAIMANT IS THE PATIENT, SECTION II MUST BE COMPLETED BY PHYSICIAN MAKING THE RECOMMENDATIONS OF CARE AND RELOCATION, IF NOT, PROCEED TO SECTION III.

SECTION II

Yes No 1. In your opinion, has the patient been able to work? If you answered no, please complete the following:

a. The patient was unable to work full-time as of _____

b. The patient was _____ will be able to work full-time as of _____

c. Are there any other work restrictions (lifting, driving, walking, etc.)? Please list and specify:

2. In your opinion, was it necessary for the patient to: **Date Patient Advised**

Yes No a. Take time off from work for treatment and/or recovery? _____

Yes No b. Change occupations? _____

Yes No c. Move to another area? _____

COMPLETE ONLY IF APPLICABLE

3. Prenatal 4. Postnatal

a. Expected date of birth _____ c. Date of birth _____

b. Patient should not work after _____ d. Patient can work full-time by _____

SECTION III

Yes No 1. In your opinion, did the patient need full-time care during the period of treatment and/or recovery?

Yes No 2. Was the claimant's presence necessary in providing care/treatment of the patient?

a. Type of care: _____ Date needed: _____

PHYSICIAN'S NAME (Printed) _____ PHONE NO. _____

PHYSICIAN'S ADDRESS (No., Street) _____

CITY _____ STATE _____ ZIP CODE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Unemployment Insurance
P.O. Box 29225, Mail Drop 5895
Phoenix AZ 85038-9225
Fax: 602-364-1210 or 520-770-3357

**PLEASE RETURN COMPLETED FORM TO THE PATIENT OR MAIL/FAX
TO THE ABOVE ADDRESS/FAX NUMBER.**

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office manager; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. Ayuda gratuita con traducciones relacionadas con los servicios del DES esta disponible a solicitud del cliente.