UB-296-FF (5-18)

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

a. Expected date of birth _____

b. Patient should not work after _____

4. Postnatal

c. Date of birth _____

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.