

Quit for Medical Reasons Questionnaire

**IMPORTANTE
TENGA ESTO TRADUCIDO INMEDIATAMENTE**

Case No:

Name:

SS #:

In your application for unemployment benefits, you indicated that you quit your job because you have medical problems. The following information is needed to determine your eligibility for benefits.

- Please complete this form and return it by mail or fax to the office indicated on the coversheet. Your form must be received within ten (10) days or a decision will be made based on available information.

(Note: ***IF YOU RECEIVED MEDICAL TREATMENT FOR THIS PROBLEM***, a physician's certification is also required. Please submit the enclosed form, as completed by the physician, by the above-referenced time limitation.)

1. Please explain the nature of your illness? _____

2. Did your job cause or aggravate your medical condition? Yes No

3. Did you seek medical attention? Yes No

If yes, did your doctor or healthcare provider advise you to quit your job? Yes No

If no, what advice was given to you with respect to your job and your medical problem? _____

4. What is the name of the doctor or healthcare provider? _____

What is the address of the doctor or healthcare provider? _____

5. Did you tell your employer about your medical condition? Yes No If yes, when? _____

Did your employer attempt to accommodate you? Yes No Please explain. _____

6. What efforts did you make to remedy your problem with your employment before leaving? _____

7. Is your illness weather related? Yes No Please explain. _____

Was relocation to another climate recommended by your doctor? Yes No If yes, please explain. _____

8. Has your doctor or healthcare provider released you to return to work? Yes No

If yes, when? _____ Do you have any restrictions? Yes No

If yes, please explain. _____

9. Are you physically and mentally able to work? Yes No If no, please explain. _____

Are you available for full time work? Yes No If no, please explain. _____

If yes, what kind of work are you seeking? _____

Do you have experience or training in the type of work you are seeking? Yes No

CERTIFICATION

Print your name: _____

SS #: _____

Signature: _____

Date: _____

Telephone: _____

I certify that the information I have provided above is true and correct, knowing the law provides penalties for false statements or the withholding of facts. I understand that a copy of the document may be given to any interested party upon request. If my claim for unemployment compensation benefits is approved, I understand that the decision could be reversed by a higher authority, and I agree to repay any amounts for which it is determined I am not eligible.