UC-28 (R. 7/17/15)

CONNECTICUT DEPARTMENT OF LABOR

Partner of the American Job Center Network

PHYSICIAN'S CERTIFICATION OF CLAIMANT'S HEALTH

IMPORTANTE
TENGA ESTO TRADUCIDO INMEDIATAMENTE

Claimant's Name and Address:

Case No:
SSN #:

I authorize the release to the Connecticut Department of Labor of such medical information that may be required to determine my eligibility for Unemployment Compensation Benefits.

CLAIMANT SIGNATURE REQUIRED **DATE**

The above referenced individual has filed a claim for unemployment benefits and has named you as his doctor or healthcare provider. In order to properly determine eligibility, we require the information requested below. Please print or type your response. Additional remarks may be noted on the back of this form.

1. Is this individual under your care? ☐ Yes ☐ No

2. What is the nature of his/her illness?

3. If the individual recently separated from employment due to this medical condition, in your professional opinion, did working conditions cause or aggravate the medical condition?
   ☐ Yes ☐ No If "yes," how?

4. In your professional opinion, was it necessary for the individual to leave his/her position for health reasons?
   ☐ Yes ☐ No Please explain:

5. Is the individual able to work full time? ☐ Yes ☐ No

If "yes," when did the individual become able to work full time?
Please explain any restrictions:

Print name of person completing form:

Signature: _____ Title: _____

Telephone #: _____ Date: _____ Fax #: _____