**Department of Unemployment Assistance**
Commonwealth of Massachusetts
Executive Office of Labor & Workforce Development

# Health Care Provider's Statement of Capability

**To Health Care Provider:**
Please fill out this form then return it to the patient. Your answers help us decide if this claimant qualifies for unemployment benefits. *Deadline:* The claimant must send us your statement by **[DueDate].**

1. Patient's name: _____
2. Patient's address: _____
3. Date you first treated patient: _____
4. Date you last saw patient: _____
5. Conditions you treated patient for: _____

6. Has the patient been able to work at all since [ClaimEffectiveDate]? *(Check one):* ☐ Yes ☐ No
7. Is the patient able to work **now**, **full-time** with no restrictions? *(Check one):* ☐ Yes ☐ No

| If ***Yes…*** | If ***No…*** |
|---|---|
| Date patient became able to return to work full-time, with no restrictions: _____ | Date patient *first* became unable to return to work full-time:<br>Reason(s) patient **can't** work full-time without restrictions: _____<br>If the patient **can** work full-time *with* restrictions, list the restrictions: _____ |

8. Is the patient able to work **now**, **part-time** with no restrictions? *(Check one):* ☐ Yes ☐ No

| If ***Yes…*** | If ***No…*** |
|---|---|
| Date patient became able to return to work part-time, with no restrictions: _____ | Reason(s) patient **can't** work part-time without restrictions: _____<br>If the patient **can** work part-time *with* restrictions, list the restrictions: _____ |

9. If the patient cannot work at all now, date you anticipate they can return to work: _____
10. If the patient is pregnant, what is the baby's due date? _____
11. Use this space to add any other information about this patient's ability to work (or attach more pages, if needed): _____

Health care provider name: _____ Phone: _____
Address: _____
I am a licensed health care provider in the State of: _____
Signature: _____ Date of Statement: _____