Employment Security Division
Claims Center
500 East Third Street
Carson City, NV 89713-0035
North Tel (775) 684-0350
South Tel (702) 486-0350

DETR
Nevada Department of Employment, Training and Rehabilitation
ONE NEVADA - Growing A Skilled, Diverse Workforce

99999
http://www.nvdetr.org

Name:
Address:
City, State Zip:

Claimant ID:
Re: Medical Form
Date Mailed:

MEDICAL STATEMENT

To Claimant: Please take this form to your physician for completion and return it as soon as possible. Failure to provide the required information by the date shown could result in a delay or denial of unemployment benefits.	**To Physician:** Please provide the medical information requested below needed to determine the claimant's eligibility for unemployment benefits. Please complete all fields. We appreciate your cooperation in this matter.

Patient's Name:		
1. Dates patient was under my care - From: To:		
2. Nature of illness or disability *please use layman terms:*		
3. Date illness or disability occurred:		
4. Was patient hospitalized for treatment of an emergency or life-threatening condition?	☐ Yes	☐ No
5. Did you advise the patient to quit his or her job for health reasons?	☐ Yes	☐ No
5a. If "Yes", please provide the date the claimant was so advised:		
6. Did you advise the claimant to quit his/her job due to a family member's medical problem?	☐ Yes	☐ No
6a. If "Yes", please provide the date that claimant was so advised:		
7. Did you advise the claimant to relocate for medical reasons?	☐ Yes	☐ No
7a. If "Yes", please provide the date claimant was so advised:		
8. Did you advise claimant to relocate due to medical problems of a family member?	☐ Yes	☐ No
8a. If "Yes", please provide the date claimant was so advised:		
9. If the patient is the claimant, has he/she been unable to work while under your care?		
9a. If "Yes", please provide the dates unable to work - From: To:		
10. If the patient is the claimant, is he/she released to return to work in the following jobs?		
Primary Occupation:	☐ Yes	☐ No
Secondary Occupation:	☐ Yes	☐ No
Date released for work, or, if not currently released, anticipated release date:		
11. Please describe any work limitations the patient may have relative to the occupation(s) shown:		
12. If claimant is under your care due to pregnancy, please provide the expedited delivery date:		
13. Is claimant needed to provide ongoing care for the health of a family member?	☐ Yes	☐ No

14. If claimant is undergoing elective surgery, is the surgery medically necessitated? ☐ Yes ☐ No	
14a. If "Yes", please provide brief statement of reason:	
15. Other information:	
Please return both pages of this form to the above address or fax them to: **(775) 684-0338** or **(702) 486-7987**	Physician's Signature: _____ Date: _____ Printed Name, Address and Phone: (Rubber Stamp OK) _____ _____ _____ _____ _____