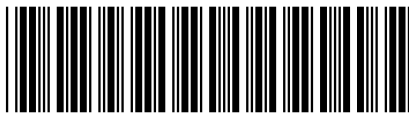THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF UNEMPLOYMENT ASSISTANCE

417252256

BREZANOVA, ANDREA
PO Box 3550
Nantucket, MA 02584-3550

CLAIMANT ID: 1543770

CLAIM ID: 202201
March 13, 2023

Issue ID #: 0079 4637 61-01

Health Care Provider's Statement of Capability

The Healthcare Provider's Statement of Capability is a <u>required</u> statement only if you have indicated you are <u>not</u> capable of working during weekly certification. Failure to return a completed form to the Department of Unemployment Assistance (DUA) for consideration by your deadline may result in disqualification. This document should be completed by a licensed physician or medical practitioner who **is either familiar with the patient's condition, or has reviewed the patient's medical records.** Once completed, patient is responsible for returning this form to DUA by .

Patient's Name:_____ Patient's Address:_____

Date you began treating patient: _____ Date you last saw patient: _____

What is the nature of the condition you are treating the patient for?

_____

Has the patient been able (or capable) to work since 2/19/2023: (Check Box) Y ☐ N ☐

Is the patient currently able to work in a full-time capacity with no restrictions? (Check Box) Y ☐ N ☐

If yes, when did the patient become able to return to work full-time? _____

If no, on what date did the patient become unable to work full-time? _____

If no, list why the patient cannot work full-time without restrictions, or, if the patient can work with restrictions, explain the restrictions.

_____

Is the patient currently able to work in a part-time capacity with no restrictions? (Check Box) Y ☐ N ☐

If no, list why the patient cannot work part-time or explain what restrictions the patient has in his/her ability to work in a part-time capacity?

_____

If the patient is unable to work, when do you anticipate the patient will be able to return to work?

_____

If the patient is pregnant, what is the expected date of delivery? _____

Please list any other information regarding the patient's capability to work full-time:

_____

_____

_____

THIS STATEMENT MUST BE SIGNED PERSONALLY BY THE HEALTHCARE PROVIDER

I am a duly licensed physician/practitioner in the State of:_____

Name of physician/practitioner:_____

Signature:_____

Address:_____

Date of Statement:_____ Contact Phone Number:_____

Notice/Disclaimer

The information you provide will be used by the Department of Unemployment Assistance solely to determine whether the named individual is capable of performing suitable work, a condition of eligibility for unemployment benefits.

Patient is responsible for returning this form to DUA by **.**

RETURN THIS FORM:

You can upload the completed form by logging in to your MA DUA account at www.mass.gov/dua. Go to your "Home Page", "View and Maintain Account Information" and select "Monetary and Issue Summary".
Select the Issue Identification Number 0079 4637 61-01 and use the Upload button available to upload supporting documentation.

Or mail it to:

Department of Unemployment Assistance
Central Document Processing Unit
100 Cambridge St, 4th floor, Suite 400
Boston, MA 02114