Health Care Provider Section

Instructions

Montana unemployment law requires this form be completed and signed by any of the following: physician, dentist, chiropractor, advanced practice registered nurse, nurse practitioner, physical therapist, clinical psychologist, or physician assistant. Please complete all fields and return the form to the claimant.

Date of first exam:

Date of most recent exam:

Diagnosis of this individual's illness/injury/disability (please use lay terms).

While under your care was there any time this individual was not able to work full time?

Yes ☐ If Yes, dates not able:

No ☐

Indicate the individual's current ability to work:

Full-time without restriction ☐

Date released to work:

Full-time with restrictions ☐

Date released with restrictions:

Hours per week the individual can work:

Explain restrictions:

Part-time only ☐

Date part-time restrictions began:

Hours per week the individual can work:

Not able to work at all ☐

Date inability to work began:

Explain inability to work:

Did you advise the individual to change occupations?

Yes ☐ Date Advised:

No ☐

Are the individual's restrictions/limitations permanent or long-term?

Yes ☐ No ☐

Comments:

Signature Printed Name

Date

License Number Phone Number

Address