Division of Unemployment Insurance
Unemployment Insurance Benefits Services
P.O. Box 400, Denver, CO 80201-0400

COLORADO
Department of
Labor and Employment

MEDICAL STATEMENT

Section 1. Consent to Release Medical Information

Complete this section to authorize the physician or medical practitioner to provide information to the Division of Unemployment Insurance (UI). You are responsible for returning this form. See instructions in **Section 3**.

I consent to release the requested information for the purposes of processing my claim for unemployment benefits with the understanding that the information is for use in determining my eligibility and entitlement for UI benefits in accordance with the Colorado Employment Security Act 8-73-108 (4)(b).	
Claimant Signature	Date
Claimant Name (print)	

Section 2. Medical Information

To be completed by the physician or medical practitioner only.

The person named has applied for UI benefits. Obtaining the information requested below will help us make a determination of eligibility and entitlement. Any alteration must be initialed. Your cooperation in providing this information is appreciated.		
Medical Condition (State in layperson terms.)	Dates of Treatment	
	From	To

Is the patient able to return to work? ☐ Yes ☐ No

If the patient is able to return to work:

On what date was the patient able to return to work? _____

Are there any restrictions that would keep the patient from returning to his or her usual occupation? ☐ Yes ☐ No
If **Yes**, please list the restrictions (e.g., lifting restrictions, part-time work only, light-duty work)

_____

If the patient is unable to return to work:

On approximately what date will the patient be able to return to work? _____

Additional Comments		
Physician Address		Telephone Number
Physician Name	Signature	Date

Section 3. Acknowledgement

Complete and sign below only **after** the physician has completed **Section 2**. By signing your name in this section, you are confirming that you understand the information provided by the physician. Then, upload the completed form into your MyUI+ account at ColoradoUI.gov or mail to the address above.

I have read and understand the above statement provided by my physician.		
Claimant Signature		
Claimant ID	Last Four of SSN XXX-XX-	Date
Comments		