Massachusetts Department of
Workforce Development
Division of Unemployment Assistance

HEALTH CARE PROVIDER'S STATEMENT OF CAPABILITY

ALL INFORMATION REQUESTED IN THIS FORM IS TO BE USED SOLELY IN DETERMINING THE VALIDITY OF A CLAIM FOR UNEMPLOYMENT INSURANCE BENEFITS FILED WITH THIS DEPARTMENT ON _____ BY THIS CLAIMANT.

All information transmitted to the Division of Unemployment Assistance relating to this worker shall be absolutely privileged and shall not be subject matter in any action of slander or libel in any court of the Commonwealth of Massachusetts.

G. L. Chapter 151A, Section 46 (a)

NAME S.S.A. NO. ☐☐☐ ■ ☐☐ ■ ☐☐☐☐

ADDRESS

1. HAVE YOU TREATED THE ABOVE-NAMED CLAIMANT SINCE ?..... YES NO
2. APPROXIMATE PERIOD OF TREATMENTS? FROM: TO:
3. IN YOUR OPINION, DID CLAIMANT'S ILLNESS REQUIRE SUSPENSION OF WORK?..... YES NO
   ON WHAT DATE? MONTH DAY YEAR
4. WHAT WAS THE NATURE OF CLAIMANT'S ILLNESS AT THAT TIME?
5. WAS CLAIMANT ABLE TO DO SOME TYPE OF FULL-TIME WORK ON.....?..... YES NO
6. DO YOU CONSIDER CLAIMANT NOW ABLE TO WORK AT REGULAR OCCUPATION?..... YES NO
7. IF NOT, IS CLAIMANT NOW PHYSICALLY ABLE TO DO SOME OTHER TYPE OF FULL-TIME WORK?..... YES NO
8. IF NOT ABLE TO PERFORM SOME TYPE OF FULL-TIME WORK, IS THE CLAIMANT CAPABLE OF PERFORMING PART-TIME WORK? YES NO
9. IF YOU ANSWERED YES TO QUESTION 8, WHAT IS THE EXPECTED DURATION OF THE CLAIMANT'S LIMITATION TO PART-TIME WORK?
   _____ WEEKS _____ MONTHS _____ INDEFINITELY
10. ON WHAT DATE WAS CLAIMANT FIRST ABLE TO ACCEPT FULL-TIME WORK OF SOME NATURE? MONTH DAY YEAR
11. IF CLAIMANT IS PREGNANT, WHAT IS THE EXPECTED DATE OF DELIVERY?..... MONTH DAY YEAR
12.
13.

REMARKS:

DATE ISSUED:

THIS STATEMENT MUST BE SIGNED PERSONALLY BY THE PROVIDER

I AM A DULY LICENSED HEALTHCARE PROVIDER IN THE STATE OF:

SIGNED:

ADDRESS:

DATE OF THIS STATEMENT:

RETURN THIS FORM TO:

Attention:

Commonwealth of Massachusetts
Form 0268 Rev. 11-07