

Department of Workforce Development  
UI Hearing Office  
P.O. Box 7975  
Madison, WI 54707

## Medical Report

Phone: (608) 266-8010  
Fax: (608) 327-6498

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Date sent:

Date due:

SSN: \*\*\*-\*\*-\*\*\*\*

UI Account:

Hearing No.:

Appellant:

Section 108.09(4m) of the Wisconsin Statutes provides that the contents of certified reports by qualified experts may be admitted as evidence in an unemployment benefit appeal, instead of requiring the expert to testify at a hearing.

If you decide that medical evidence is necessary for the upcoming appeal hearing, please have your doctor or other treating health care professional complete the enclosed medical report. The last page includes instructions for the doctor.

Fill out and sign only the "Claimant Authorization for Release of Patient Information" before giving the report form to your doctor or health care provider to complete.

**Make sure you return the completed form to this office by the date due.** If you have any questions, call us at (608) 266-8010 between 7:45 a.m. and 4:30 p.m. weekdays.

Enclosure: UCB-474  
Instructions for Treating Health Care Professional

<b>Department of Workforce Development</b> UI Hearing Office P.O. Box 7975 Madison, WI 54707  Phone: (608) 266-8010 Fax: (608) 327-6498	<b>Medical Report</b>	
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**CLAIMANT AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION**

The purpose of this release is to resolve the claimant's unemployment benefit eligibility. This information will be shared with department personnel and other parties to the disputed claim. Personal information you provide may be used for secondary purposes. [Privacy Law, s. 15.04(1)(m), Wis. Stats.] I hereby request and authorize **(print Health Care Professional's name)**

to release to the Department of Workforce Development specific information requested on this form together with any supporting documentation or reports from my medical record. I further understand that the information disclosed may include reference to or treatment of alcohol/drug use or mental illness. **This authorization will remain in effect unless I revoke it by written notification.**

Claimant's signature \_\_\_\_\_ Date \_\_\_\_\_

**TREATING HEALTH CARE PROFESSIONAL'S REPORT**

Complete any subsequent sections marked  and the Certification section.

**I. MEDICAL HISTORY**

- A. The claimant was under my care from \_\_\_\_\_ to \_\_\_\_\_ AND/OR was most recently seen by me on \_\_\_\_\_.
- B. Diagnosis: \_\_\_\_\_
- C. Diagnosis was based on (check all that apply):  Examination  Claimant's Statement  Other (specify) \_\_\_\_\_

**II. SUBSTANCE ABUSE AND MENTAL ILLNESS** (Check all that apply).

- Alcohol Abuse  Drug Abuse  Mental Illness
- A. Explain how the condition affects the claimant: \_\_\_\_\_
- B. Was the claimant required to take medication(s) to control the condition(s)?  Yes  No  
Medication(s) side effects: \_\_\_\_\_
- C. Did the claimant request to seek admission to a substance abuse or mental treatment facility?  Yes  No  
Was the claimant advised to seek admission?  Yes  No  
If no, please explain: \_\_\_\_\_
- If yes, was the claimant admitted for treatment?  Yes  No  
This treatment was:  Inpatient (Dates): \_\_\_\_\_ AND/OR  Outpatient (Dates): \_\_\_\_\_
- D. In your opinion, can the claimant abstain from the use of alcohol and/or drugs? (Please explain:) \_\_\_\_\_

**III. ABILITY TO PERFORM SPECIFIC DUTIES**

- A. Was the claimant able to perform the following work: \_\_\_\_\_  
as of \_\_\_\_\_?  Yes  No
- B. Was the claimant advised to seek other work?  Yes  No If yes, date advised? \_\_\_\_\_
- C. What type of work was the claimant recommended to seek? \_\_\_\_\_

IV. GENERAL ABILITY TO WORK

As of \_\_\_\_\_, was the claimant able to perform any type of work?

- No. Claimant cannot work due to the medical condition(s) **reported on this form.**  
As of \_\_\_\_\_ the claimant was/will be able to return to work **without** restrictions. **(If applicable)**
- Yes. Claimant may work, but must limit the activities and/or hours of work. **(COMPLETE SECTION V.)**  
As of \_\_\_\_\_ the claimant was/will be able to return to work **without** restrictions. **(If applicable)**
- Yes. Claimant is able to work **without** restrictions.

V. RESTRICTIONS

A. How many hours can the claimant work per week based on the restrictions listed on this form or for other medical reasons.  
\_\_\_\_\_ **Hours Per Week**

B. Check one of the following classifications of work that the claimant is able to perform:

- Sedentary Work** If a claimant is restricted to less than 10 pounds of lifting, carrying, pushing or pulling, then s/he is available for sedentary work only. Or if a claimant is required to sit most of the time and can only walk or stand occasionally (1-33% of the time), s/he is available for sedentary work only.
- Light Work.** If a claimant is restricted to not more than 20 pounds of lifting, carrying, pushing or pulling, then s/he is available for light work only. Or if a claimant is not to walk or stand to a significant degree (34-67% of the time), but is supposed to sit most of the time, s/he is available for light work only. If the claimant cannot use arm or leg motions to a significant degree, then the claimant is available for light work only.
- Medium Work.** If a claimant is restricted to not more than 50 pounds and to occasional (1-33% of the time) of lifting, carrying, pushing or pulling, then s/he is available for medium work only. A claimant available for medium work would have no walking or standing restrictions.
- Heavy Work.** If a claimant is restricted to not more than 100 pounds and/or is restricted to 25 or 50 pounds frequently (67% +); then s/he is available for heavy work only. A claimant available for heavy work would have no walking or standing restrictions.
- Very Heavy Work.** There are no restrictions regarding very heavy work.

C. Check the level of restricted activity **for all that apply to the claimant**

<b>Stooping</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No stooping</li><li><input type="checkbox"/> Can stoop occasionally (1 to 33% of the time)</li><li><input type="checkbox"/> Can stoop frequently (34 to 67% of the time)</li></ul>	<b>Balancing</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Cannot rely on balance</li></ul>
<b>Climbing</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Must be avoided</li><li><input type="checkbox"/> Can climb occasionally (1 to 33% of the time)</li></ul>	<b>Hearing</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Cannot hear</li><li><input type="checkbox"/> Has limited hearing</li></ul>
<b>Crouching</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Must be avoided</li><li><input type="checkbox"/> Can crouch occasionally (1 to 33% of the time)</li></ul>	<b>Talking</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Cannot speak accurately, loudly, or quickly</li></ul>
<b>Crawling</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Must be avoided</li><li><input type="checkbox"/> Can crawl occasionally (1 to 33% of the time)</li></ul>	<b>Feeling</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No feeling in fingertips</li></ul>
<b>Reaching</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No reaching</li><li><input type="checkbox"/> Occasionally (1 to 33% of reaching ability)</li><li><input type="checkbox"/> Frequently (34 to 67% of reaching ability)</li></ul>	<b>Taste/Smell</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Cannot distinguish taste or smell</li></ul>
<b>Handling (seizing, holding, grasping &amp; turning activities)</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No handling</li><li><input type="checkbox"/> Can handle occasionally (1 to 33% of the time)</li><li><input type="checkbox"/> Can handle frequently (34 to 67% of the time)</li></ul>	<b>Near Vision Clarity</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No vision clarity of 20 inches or less</li><li><input type="checkbox"/> Has difficulty with clarity of 20 inches or less</li></ul>
<b>Fingering (picking, pinching, &amp; fingering activities)</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No fingering</li><li><input type="checkbox"/> Occasionally (1 to 33% of finger dexterity)</li><li><input type="checkbox"/> Frequently (34 to 67% of finger dexterity)</li></ul>	<b>Far Vision Clarity</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No vision clarity 20 feet or more</li><li><input type="checkbox"/> Has difficulty with clarity of 20 feet or more</li></ul>
<b>Kneeling</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Cannot kneel</li><li><input type="checkbox"/> Can kneel occasionally (1 to 33% of the time)</li></ul>	<b>Depth Perception</b> <ul style="list-style-type: none"><li><input type="checkbox"/> No depth perception</li><li><input type="checkbox"/> Limited depth perception</li></ul>
	<b>Color Visibility</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Color blind</li><li><input type="checkbox"/> Has difficulty identifying or seeing colors</li></ul>
	<b>Field of Vision</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Very limited field of vision</li><li><input type="checkbox"/> Some limitations in field of vision</li></ul>

**ADDITIONAL QUESTIONS FOR THE TREATING HEALTH CARE PROFESSIONAL TO ANSWER:** (These questions may be answered here or you may attach documents. *Remember to sign and date this form.*)

**ADDITIONAL COMMENTS BY THE TREATING HEALTH CARE PROFESSIONAL:** (Any additional information may be provided here or you may attach documents. *Remember to sign and date this form.*)

**CERTIFICATION IS REQUIRED.** I hereby certify with full knowledge of the penalty of fine and / or imprisonment, as provided in §943.39 of the Wisconsin Statutes, that this report, together with any attached documents, truly and correctly sets forth the claimant's history, my findings, diagnosis and opinion.



Signature of Health Care Professional: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title \_\_\_\_\_

Phone number: (\_\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_