Medical Report

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

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

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

Department of Workforce Development UI Hearing Office P.O. Box 7975 Madison, WI 54707 Phone: (608) 266-8010 Fax: (608) 327-6498	**Medical Report** Date sent: **Date Due:** Hearing No.:

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: pro golf management intern

_____

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**

Stooping
- ☐ No stooping
- ☐ Can stoop occasionally (1 to 33% of the time)
- ☐ Can stoop frequently (34 to 67% of the time)

Climbing
- ☐ Must be avoided
- ☐ Can climb occasionally (1 to 33% of the time)

Crouching
- ☐ Must be avoided
- ☐ Can crouch occasionally (1 to 33% of the time)

Crawling
- ☐ Must be avoided
- ☐ Can crawl occasionally (1 to 33% of the time)

Reaching
- ☐ No reaching
- ☐ Occasionally (1 to 33% of reaching ability)
- ☐ Frequently (34 to 67% of reaching ability)

Handling (seizing, holding, grasping & turning activities)
- ☐ No handling
- ☐ Can handle occasionally (1 to 33% of the time)
- ☐ Can handle frequently (34 to 67% of the time)

Fingering (picking, pinching, & fingering activities)
- ☐ No fingering
- ☐ Occasionally (1 to 33% of finger dexterity)
- ☐ Frequently (34 to 67% of finger dexterity)

Kneeling
- ☐ Cannot kneel
- ☐ Can kneel occasionally (1 to 33% of the time)

Balancing
- ☐ Cannot rely on balance

Hearing
- ☐ Cannot hear
- ☐ Has limited hearing

Talking
- ☐ Cannot speak accurately, loudly, or quickly

Feeling
- ☐ No feeling in fingertips

Taste/Smell
- ☐ Cannot distinguish taste or smell

Near Vision Clarity
- ☐ No vision clarity of 20 inches or less
- ☐ Has difficulty with clarity of 20 inches or less

Far Vision Clarity
- ☐ No vision clarity 20 feet or more
- ☐ Has difficulty with clarity of 20 feet or more

Depth Perception
- ☐ No depth perception
- ☐ Limited depth perception

Color Visibility
- ☐ Color blind
- ☐ Has difficulty identifying or seeing colors

Field of Vision
- ☐ Very limited field of vision
- ☐ Some limitations in field of vision

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: _____