Please return to: Lower Appeals Division, Dept. of Labor
1100 N. Eutaw St., Rm. 511, Baltimore, MD 21201
Fax: 410-767-2532; e-mail: UILowerAppeals.labor@maryland.gov

MEDICAL STATEMENT

Claimant's Name:
Claimant's SSN:

1. Claimant's illness, injury, or pregnancy _____

2. Date of first treatment for this illness, injury, or pregnancy _____

3. Date claimant became unable to work due to this illness, injury, or pregnancy _____

4. If a procedure surgery was performed, was it ☐ elective or ☐ medically necessary Date performed _____

5. Was this claimant's illness or injury directly caused by his/her most recent employment?

   ☐ YES ☐ NO

   If YES, explain how _____

   _____

6. Because of this illness, injury, or pregnancy, was the claimant advised by you to (check the box below that applies):

   ☐ Quit his/her job.

   ☐ Stop working temporarily.

   ☐ Neither quit nor stop working temporarily.

   NOTE: If advised to quit his/her job or stop working temporarily, please provide:
   Date claimant was so advised _____
   Length of time anticipated that the claimant would not be able to work _____
   Name and title of medical care provider who gave this advice _____
   Why the claimant was advised to do so _____
   _____

7. Can this claimant work full time now without restrictions or limitations? YES ☐ NO ☐

   If YES, provide the date the claimant was released for full time work without restrictions/limitations.
   _____

   If NO, describe the restrictions/limitations you have placed on this claimant's ability to work and provide the date you think these restrictions will end allowing the claimant to return to full time work_____
   _____

If these restriction/limitations are permanent, please check this box. ☐

Medical Care Provider's Name and Title (Please Print) _____
Medical Care Provider's Signature _____ Date Signed_____
Telephone Number _____