

# HEALTH CARE PROVIDER'S CERTIFICATION

K-BEN 312 Web (Rev. 5-14)

MAIL: Unemployment Contact Center  
P.O. Box 3539  
Topeka, KS 66601-3539  
FAX: (785) 296-3249  
EMAIL\*: KDOLforms@dol.ks.gov

Claimant name: \_\_\_\_\_ Social Security number: \_\_\_\_\_

Health care information is required to determine if you are eligible for unemployment insurance benefits. Take this form to your health care provider for completion and then sign the certification. Return this form within **seven days** of the date you filed your claim. **Failure to reply by this date may result in a denial of benefits or possible overpayment.**

**PATIENT INFORMATION:** This individual has recently consulted you regarding a medical condition. The following information is required for determination of the individual's eligibility for unemployment insurance benefits.

Information provided for:  Claimant  Claimant's family member Relationship to claimant: \_\_\_\_\_

Did you advise claimant to leave work?  YES  NO

If YES:  Permanent date advised (mm/dd/yyyy): \_\_\_\_\_

Temporary date advised (mm/dd/yyyy): \_\_\_\_\_ Expected release to work date (mm/dd/yyyy): \_\_\_\_\_

Individual was examined or treated for a medical condition from (mm/dd/yyyy): \_\_\_\_\_ to \_\_\_\_\_

Describe the medical condition in lay terms. Include the prognosis and advice given (i.e., change of climate, surgery, additional treatment, hospitalization, etc.). Attach supporting documents, if applicable.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Became unable to work on (mm/dd/yyyy): \_\_\_\_\_

Is claimant able to continue employment in customary occupation?  YES  NO

Was able to return to full-time work on (mm/dd/yyyy): \_\_\_\_\_  Unknown at this time

Able to perform full-time work in another occupation?  YES  NO If YES, date able to return to work: \_\_\_\_\_

Type of work: \_\_\_\_\_

Restrictions pertaining to full-time employment?  YES  NO

Restrictions: \_\_\_\_\_

## HEALTH CARE PROVIDER INFORMATION:

Health Care Provider signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

Printed name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**CLAIMANT'S RELEASE:** I herewith consent to the release of the above information to the Kansas Department of Labor with the understanding that it is for confidential use by the Department in determining my eligibility for unemployment insurance benefits.

Claimant's signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

\*See important Email Notice on website.