CONNECTICUT Labor

Form UC-27: Request for Physician's Certification for Part-time Availability

State of Connecticut Department of Labor, Employment Securing Adjudications

Claimant's Name

First Name

Last Name

Social Security Number

Enter the 9 digits of the claimant's Social Security Number (SSN).

Instructions to Claimant

The information on this completed questionnaire is needed for the hearing which has been scheduled to determine your availability for work and eligibility for unemployment benefits. See the *Notice to Claimant of Hearing* for the date and time of your telephone hearing. *Sign the release on the bottom of the other side of this form and then have your physician respond to the questions below prior to your hearing date.*

Please mail or fax this form to the office indicated on the notice of hearing. The completed form must be received no later than the date and time of the scheduled hearing, or within 10 days of the mail date of the hearing notice if you are filing an interstate claim.

If you do not have a scheduled hearing, return the completed form as directed by the adjudicator.

Unemployment Compensation Law Regarding Availability for Claimants with a Disability

Effective October 1, 2006, Public Act 06-171 exempts an unemployed person with a disability from the unemployment compensation (UC) requirement of looking for full-time work and allows him eligibility if he meets other requirements. A claimant can qualify for UC if he: 1) provides documentation from a physician that (a) he has a physical or mental impairment that is chronic or expected to be long-term or permanent and (b) the impairment leaves him unable to work full-time, and 2) establishes, to the satisfaction of the UC administrator, that the impairment does not prevent him from performing part-time work.

Instructions to Physician

The above-named individual has filed a claim for unemployment benefits. In order to properly determine eligibility, we require the information requested below. Please complete the following form.

Questions for Claimant's Physician

Are you a licensed physician?

- ◯ Yes
- ◯ No

Does the individual have a physical or mental impairment?

- ◯ Yes
- ◯ No

If the individual does have a physical or mental impairment. Please use the space below to describe the nature of the impairment.

Enter your response in the space above.

Approximate Date on which Impairment Commenced:

Month Day Year

Which of the following describes the individual's impairment?

- ◯ Chronic
- ◯ Expected to be long-term
- ◯ Permanent in nature

In your professional opinion, will the impairment render the individual unable to work full-time hours (35 or more hours per week) on a continuing basis?

- ◯ Yes
- ◯ No

Assessment of Individual's Inability to Work

If (in your professional opinion) the impairment will render the individual unable to work full-time hours on a continuing basis, please answer the following questions.

Estimated number of hours per week the individual is medically permitted to work:

1 week = 168 hours. Number of weekly hours cannot exceed this maximum.

Estimated number of hours per day the individual is medically permitted to work:

1 day = 24 hours. Number of daily hours cannot exceed this maximum.

Is there a medical limitation as to the time of day (e.g. work schedule) that the individual is able to work?

- ◯ Yes
- ◯ No

If there is a medical limitation as to the time of day (e.g. work schedule) that the individual is able to work, please use the space below to explain.

Enter your response in the space above.

Please use the space below to describe any medical restrictions on the type of work the individual is able to perform.

Enter your response in the space above.

Physician Certification

Physician's Name

First Name

Last Name

Physician's Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Physician's Phone Number

Area Code | Phone Number

Physician's Fax Number

Area Code | Phone Number

Physician's Signature

Date

Month | Day | Year

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