SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

REEMPLOYMENT ASSISTANCE DIVISION

420 S. Roosevelt St., PO Box 4730, Aberdeen, SD 57402-4730
Tel: 605.626.2452 Fax: 605.626.3172 dlr.sd.gov/ra

MEDICAL STATEMENT OF ABILITY TO WORK

PART I: CLAIMANT

Instructions: Complete Part I of this form and give to your physician to complete Part II. Any alterations or changes to the information below must be initialed by your physician or may void this document.

Name: Date of Birth:

Last four of SSN:

Most recent employer: Position held:

Recently sought medical care for (symptoms, illness, injury):

Name of physician:

I am able to work at this time: ☐Yes ☐No

If you feel you are physically able to work, list the types occupations you will be seeking for work:

RELEASE OF INFORMATION

I hereby consent with my signature below to the release of information from my doctor or medical provider to the Reemployment Assistance (RA) Division for the confidential use of that agency in determining my eligibility for RA benefits.

Claimant Signature: ____ Date:____/____/_______

PART II: PHYSICIAN

Instructions: The information requested below will enable the RA Division to make an eligibility determination for RA benefits for the individual named above. Your cooperation in providing this information will be appreciated. This information may be provided to the patient. **Please FAX or MAIL this completed form within the next five days to the address at the top of the form.** Thank you for your assistance. *(Please note: DLR is not responsible for fees or charges for completing this document).*

Nature of **CONDITION, ILLNESS, OR INJURY**:_____________________________________ **Date began:**________________

1. On what date did you ***first*** examine this individual for this condition/illness/injury? **Date: ___________________**
2. Most recent examination for this condition/illness/injury? **Date: ___________________**
3. Is continued employment in the most recent employer/position listed above hazardous to this individual's health? ☐Yes ☐No
4. Did you advise this individual that this employment was a health hazard, or that he/she should leave this employment? ☐Yes ☐No

   If yes, when did you advise this individual that the employment was a health hazard? **Date: ____________________**
5. At the present time is this individual physically able to work in the occupation(s) listed above? ☐Yes ☐No
6. When was/will the individual physically able to do this work: **Date: ____________________**
7. Please describe restrictions/limitations to claimant's present ability to work:

Physician's Signature:______________________________ Date: ____/____/_______ Degree/Title:____________________

Clinic Address: _______________________________________ Tel: (_____) _____ - _______Fax: (_____) _____ - _______

Name of additional contact in your office regarding this information: ____