

Instructions for NUCS-4194 Medical Statement

This statement is used to determine a claimant's ability to work as well as to verify medical advice given to a claimant about personal health or a medical situation relating to a family member.

This form must be returned to the Nevada Employment Security Division after completion. The form is NOT valid unless signed by a licensed physician, chiropractor, psychiatrist, or, in limited circumstances, a nurse practitioner or midwife (conditions apply to the final two occupations being signatories, contact a call center BEFORE having a nurse practitioner or midwife sign this document).

Next to the word To:, complete your name.

Next to the word Date:, complete the date you downloaded the form.

Leave the line "Please Respond By" blank, HOWEVER, bear in mind that you have 10 days from the date the form has been requested to return it to the office as you were directed. If that 10th day falls on a Saturday, Sunday or Legal Holiday, you have until the following business day to return the form.

On the line SSN, complete your social security number. Please verify the number, to make sure the form is not voided as inaccurate.

Example 123-45-6789

On the blank line next to "Patient's Name:", complete the name to whom this form applies. The form may NOT apply to you, especially if you quit a job to care for an ill relative or are not available for work due to the same personal needs. If the form is being used to report YOUR personal illness, injury or disability, complete this section with your information. Please print legibly.

Questions 1-14 are to be completed by a physician. Not all questions may apply, depending on circumstances. If the form relates to your personal illness, injury or disability, question 10 must include information on your primary occupation(s).

Insure that the doctor signs the form. A rubber office stamp applied in the physician's office is acceptable. The form is to be returned to the office indicated by the claims staff who directed you to complete this form. The doctor may fax the form to the appropriate fax number at the bottom of the form. If the claimant is returning the form, the form should be mailed to the address requested by the claims examiner.

Remember, this form MUST bear the signature of a doctor or listed health professional in order to be valid. Make sure that all pertinent information has been completed. Failure to return this form as directed may result in a delay or denial of benefits.