KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

HEALTH CARE PROVIDER'S CERTIFICATION

K-BEN 312 Web (Rev. 7-23)

MAIL: Unemployment Contact Center
P.O. Box 3539
Topeka, KS 66601-3539

FAX: (785) 296-3249

UPLOAD:
https://UIAssistance.GetKansasBenefits.gov

Claimant name (Last, First, MI): ________________________ Social Security number: XXX-XX-________

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, possible overpayment and collection of benefits previously received.**

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 leave date advised (mm/dd/yyyy): ____________

☐ Temporary leave 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): ____________