KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

HEALTH CARE PROVIDER'S CERTIFICATION

K-BEN 312 Web (Rev. 2-21)

REPORT FRAUD
www.ReportFraud.ks.gov

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.

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☐ 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): ______________