EMPLOYER RESPONSE—MEDICAL SEPARATION

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE.

Date:

Claimant Name:	SSN:
IDAHO FALLS LOCAL OFFICE IDAHO DEPT OF COMMERCE AND LABOR 150 SHOUP AVENUE STE 13 IDAHO FALLS ID 83402-3653 208-525-7268 (FAX)	Employer's Name, Address, Phone & Fax

Paid or to be paid:		
Gross earnings for the past 12 months $	Severance: $	On (date):
Vacation: $	Bonus: $	On (date):
Date payment will be received:	Holiday: $	On (date):
Rate of Pay per hour: $	Pension or Retirement pay was paid or will be paid:	
	$	On (date):

Supervisor's Name:	Employer's Phone#:
Start Date of Employment:	Last Day worked:
Date of Separation:	

Do you have a leave policy for employees who are unable to work? Yes ☐ (Please provide copy) No ☐

Did the claimant discuss the possibility of a leave with you? Yes ☐ No ☐

Briefly explain your leave policy.

Are you holding the claimant's job for him/her? Yes ☐ No ☐

If the claimant is on a leave beginning date _____ ending date _____

Did claimant discuss the possibility of other work with you? Yes ☐ No ☐

Do you have other work, which would accommodate the claimant's limitations? Yes ☐ No ☐

Position: Hours per day: Rate of Pay:

If yes, did you offer this work to the claimant? Yes ☐ No ☐ If not, why not?

Did the claimant provide you with verifiable information (Medical statement—visual observation) of his/her ability to work? Yes ☐ No ☐ Explain:

Please provide any additional information you believe should be considered in determining claimant's eligibility.
NOTE: PLEASE ATTACH ANY RELATED DOCUMENTATION TO SUPPORT YOUR POSITION
For example written warnings, policy manuals, time cards, personnel records, statements from first-hand witnesses, written customer complaints, police reports, and other evidence to support your statement(s)

Employer/Employer's Representative Signature: _____

Print Name: _____ Title: _____

Phone Number: _____ Date: _____