Department of Workforce Development
Unemployment Insurance Division
P.O. Box 7905
Madison, WI 53707

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Weekly Certification of Compliance by Substance Abuse Treatment Provider

The week for certifying compliance runs Sunday to Saturday.

Please return completed form by mail, fax or encrypted email within 7 days of the end of the week. Failure to return the form could result in denial of benefits to the claimant and no payment for services will be processed.

For week beginning Sunday _____/_____/_____ and ending Saturday _____/_____/_____.

Individual Information

First Name	Middle Initial	Last Name		
Address	City		State	Zip Code
Social Security Number	ID Number			

Treatment Facility Information

Treatment Facility Name			
Address	City	State	Zip Code
Contact Name	Title	Phone Number	

Treatment Facility Certification

☐ I certify for the week ending _____/_____/_____, that the individual has complied with all of the requirements of the substance abuse treatment plan.

☐ I certify for the week ending _____/_____/_____, that the individual has NOT complied with all of the requirements of the substance abuse treatment plan.

Name of Treatment Facility Employee Completing This Form	Title
Phone Number	Date / /