Department of Workforce Development
Unemployment Insurance
P.O. Box 7905
Madison, WI 53707
Fax: (608) 260-2506

Weekly Certification of Willingness to Attend/Enroll in Substance Abuse Treatment

Please sign and return completed form by mail or fax within 7 days of the close of the week for which you are certifying. Failure to respond may result in denial of benefits.

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

Provision of your Social Security Number (SSN) is mandatory per the federal Social Security Act. Your SSN is used to verify your identity. We cannot process this form without your SSN.

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

Claimant Certification

☐ For the week ending ____/____/____, I certify that I intend to enroll in and comply with a substance abuse treatment program, when services become available. I understand that penalties and overpayments may result, if I provide false or incomplete information.

Printed Claimant Name	Date / /
Claimant Signature	