West Virginia University
Medical Verification Form

Employee to Complete

Employee's Name:_____ Date of Birth:_____

Mailing Address:_____ Phone Number:_____

Work Related-Injury? yes no Personal Email (required):_____

Supervisor:_____ Employee#:_____

I hereby authorize West Virginia University to obtain any medical documentation necessary to process this request. I understand that this form needs to be completed in full and additional medical information may be required. WVU will request additional information if needed. I am aware that WVU seeks medical information in order to assess employability options including accommodation or restriction from work. Sick or annual leave charged will be determined based upon information provided. Leave determinations include Family Medical Leave Act, Parental Leave Act, ADA monitoring, use of sick leave and Catastrophic leave.

_____

Employee's Signature Date

Physician to Complete

_____

(Diagnosis or ICD-9 or 10 Code) **(Prognosis)**

_____

(Comorbidities) **(Maternity Date and Method of Delivery)**

Treatment Plan/Type of Surgery: _____

_____

Employee needs to be off work **consecutively** from _____through and including_____.

May return to work on _____ with **no restrictions.** Will be re-evaluated on _____.

For intermittent absences or work-related restrictions, please see page 2.

_____

Physician's signature Date Physician's Phone

_____

Name of physician (please print) Physician's Fax

WVU Division of Talent and Culture
Medical Management Unit
PO Box 6640 Morgantown, WV 26506-6640
Phone: (304) 293-5700 Ext 8 Fax: (304) 293-2644

Employee's Name: _____Date of Birth:_____

Intermittent Leave

Employee needs to be off work **intermittently** from _____through and including_____.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 to 12 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____times per _____week(s)_____ month(s) Duration: _____hours or ____ day(s) per episode

Work-Related Restrictions

Released to return to work on _____with the following **restrictions** through_____.

These limitations are**:** ☐ **Permanent** ☐ **Temporary**

Hours per day, please specify: _____Days per week, please specify: _____

Lifting Restricted to less than: ☐ 50 lbs. ☐ 20 lbs. ☐ 10 lbs. ☐ 5lbs. ☐ other_____ ☐ No restriction

Restrictions during a work shift

Bending/Stooping	☐ May not perform	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8+ hours	☐ No restriction
Pulling/Pushing	☐ May not perform	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8+ hours	☐ No restriction
Overhead Reaching	☐ May not perform	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8+ hours	☐ No restriction
Sitting	☐ May not perform	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8+ hours	☐ No restriction
Standing	☐ May not perform	☐ 1-3 hours	☐ 3-5 hours	☐ 5-8+ hours	☐ No restriction

If other limitations please specify:_____

_____

I hereby certify that the above information is true and correct and that it is my responsibility to give objective medical information. West Virginia University will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether the accommodation can be met in a reasonable fashion.

_____

Physician's signature Date Physician's Phone

_____

Name of Physician (please print) Physician's Fax

It is the employee's responsibility to submit these restrictions to Medical Management prior to returning to work. Medical Management will notify the employee if his/her position can be modified to meet these restrictions, or if he/she will need to remain off work on medical leave.

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