West Virginia University
Immediate Family Member
Medical Leave Verification Form

Employee to Complete

Employee's Name:_____ Date of Birth:_____

Mailing Address:_____ Phone Number:_____

Supervisor:_____ Non-WVU email (required): _____

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐Spouse ☐Parent ☐Child, under age 18

☐Child, age 18 or older and incapable of self-care because of mental or physical disability

☐Other: _____

(3) Briefly describe the care you will provide to your family member: (check all that apply)

☐Assistance with basic medical, hygiene, nutritional, or safety needs ☐Transportation

☐Physical care ☐Psychological Comfort ☐Other: _____

(4) Give your best estimate of the amount of leave needed to provide the care described: _____

_____

(5) If a reduced work schedule is necessary to provide the care described, give you best estimate of the reduced schedule you are able to work: From: _____ to _____. I am able to work _____ (hours per day) _____(days per week).

Employee Signature_____

For individuals employed by both West Virginia University (WVU) and University Health Associates (UHA): Submission of this form and/or request is an acknowledgment by the employee that all information submitted may be shared with and between WVU and UHA. The employee also acknowledges that he/she has consented to the use or disclosure by WVU and UHA of information provided.

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (____) _____ Fax: (____) _____ E-mail: _____

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
medicalmanagement@mail.wvu.edu

Employee Name: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name:_____
(Diagnosis ICD 10 Optional) (Prognosis)

(2) State the approximate date the condition started or will start: _____

(3) Provide your best estimate of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

_____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):_____
_____

☐ **Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ to _____.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date:_____.

☐ **Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is being provided)

☐ **Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

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Employee Name: _____

☐ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis_____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

(7) Due to the condition, the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) referred to other health care provider(s) for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy)_____

Provide your best estimate of the beginning date_____ and end date_____ for the treatment(s).

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/ week) _____

(9) Due to the condition, the patient (☐ was / ☐ will be) incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

Due to the condition, it (☐ was/ ☐ is/ ☐ will be medically necessary for the employee to be absent from work to provide care for the patient consecutively.

Provide your best estimate of the beginning date: _____ and the end date_____.

(10) Due to the condition it, (☐was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work to provide care for the patient on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups.

Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 12 months, episodes of incapacity are estimated to occur_____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐hours / ☐ days) per episode.

Signature of
Health Care Provider_____ Date_____

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