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): ______________________________________

Relationship to Patient: ______________________ 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.

Physician to Complete

I certify that ___________________________________(___________________) has been under my professional care
(Patient's Name) (Date of Birth)

for____.
(Diagnosis) (ICD-9 or 10 Code)

Is employee required to provide care for the patient? ____YES ____NO
Is the patient seriously ill? ____YES ____NO

If yes please indicate duration of serious condition. From:____________________ To: ________________________.

Treatment Plan:____

____

Employee needs to be off work **consecutively** from _________________through and including_________________.
AND/OR
Employee needs to be off **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

Explain the care needed by patient, and why such care is medically necessary:________________________________

____

____

____
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
medicalmanagement@mail.wvu.edu

Revised 8/29/2022