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 :____

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 Email: medicalmanagement@mail.wvu.edu

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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