

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 (optional): _____

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	<input type="checkbox"/> May not perform	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8+ hours	<input type="checkbox"/> No restriction
Pulling/Pushing	<input type="checkbox"/> May not perform	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8+ hours	<input type="checkbox"/> No restriction
Overhead Reaching	<input type="checkbox"/> May not perform	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8+ hours	<input type="checkbox"/> No restriction
Sitting	<input type="checkbox"/> May not perform	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8+ hours	<input type="checkbox"/> No restriction
Standing	<input type="checkbox"/> May not perform	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8+ hours	<input type="checkbox"/> 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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