West Virginia University
Immediate Family Member
Medical Verification Form

Employee to Complete

Employee's Name:_____ Date of Birth:_____

Mailing Address:_____ Phone Number:_____

Supervisor_____ Personal Email (required): _____

Relationship to Patient: _____

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 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 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

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

_____

_____

_____

Physician's signature Date Physician's Phone

_____

Name of physician (please print) Physician's Fax

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