West Virginia University
Immediate Family Member
Medical Leave Verification Form

Employee to Complete

Employee's Name:_____Home Phone Number:_____

Home Address:_____

Department:_____Supervisor:_____

Employee#:_____Relationship to Patient:_____

Physician to Complete

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

for _____.
(Diagnosis or ICD-9 Code) **(Comorbidities)**

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/Type of Surgery:_____

_____

Employee needs to be off work **consecutively** from_____through and including_____.

And/Or

Employee needs to be off work **intermittently** from_____through and including_____.

Physician Comments:_____.

_____

_____
Physician's signature Date Physician's Phone

_____
Name of physician (please print) Physician's Fax

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