

West Virginia University Medical Verification Form

Employee to Complete

Employee's Name: _____ Date of Birth: _____

Home Address: _____ Home Phone Number: _____

Leave due to Workers' Compensation? _____ Department: _____

Supervisor: _____ EBO Contact _____

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 Code

Prognosis

Maternity Date and Method of Delivery

Physician Comments /Treatment Plan:

This is to certify that the above mentioned employee has been under my professional care. I support his/her absence from work starting _____ through and including _____.

May return to work on _____ with no restrictions. Will be re-evaluated on _____.

IF THE EMPLOYEE HAS ANY WORK RELATED RESTRICTIONS, PLEASE SEE PAGE 2

Physician's signature

Date

Name of physician (please print)

Physician's Phone

**WVU Division of Human Resources
Medical Management Unit
PO Box 6640
Morgantown, WV 26506-6640
Phone: (304) 293-5700 Ext 8 Fax: (304) 293-2644**

THIS PAGE ONLY NEEDS TO BE COMPLETED IF THERE ARE WORK RELATED RESTRICTIONS

Patient's Name: _____ Is released to return to work on _____ with the following **restrictions:**

Hours per day Normal Schedule If limited please specify _____

Days per week Normal Schedule If limited please specify _____

Lifting Restricted to no greater than: 50 lbs. 20 lbs. 10 lbs. 5lbs. other _____

Restrictions during a work shift

Bending/Stooping 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Pulling/Pushing 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Overhead Reaching 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Sitting 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Standing 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

If other limitations please specify: _____

These restrictions are to be in effect starting _____ through and including _____.

These limitations are: **Permanent** **Temporary**

May resume regular duties on _____ **OR** Will be re-evaluated on _____.

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

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 their position can be modified to meet these restrictions, or if they will need to remain off work on medical leave.

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