West Virginia University
Immediate Family Member
Medical Leave Verification Form

Employee to Complete

Employee's Name:_____Home Phone Number_____

Home Address:_____

Department:_____Supervisor_____EBO:_____

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 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_____.

Physician Comments:_____.

_____

Physician's Name:_____Phone Number:_____Fax Number:_____

_____ _____
Physician's Signature Date

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