## West Virginia University Immediate Family Member Medical Verification Form

## **Employee to Complete**

Employee's Name:	Date of Birth:
(	
	Relationship to Patient:
Physician to Complete	
I certify that(Patient's Name)	() has been under my professional (  (Date of Birth)
for(Diagnosis)	(ICD-9 or 10 Code)
	N
	lition: From To
	Phone Number:  Personal Email (optional):  (
Employee needs to be off work consecutively	fromthrough and including
And/Or	
Employee needs to be off work intermittently	fromthrough and including
Based upon the patient's medical history and flare-ups and the duration of related incapaci episode every 3 months lasting 1-2 days):	your knowledge of the medical condition, estimate the frequency by that the patient may have over the next 6 to 12 months (e.g., 1
Frequency :times perweek(s)_	month(s) Duration:hours or day(s) per episo
Explain the care needed by the patient, and w	hy such care is medically necessary:
Physician's signature	Date Physician's Phone
Name of physician (please print)	Physician's Fax

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