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	0-3 hours	1-3 hours	3-5 hours	5-8+ hours	No restriction
Pulling/Pushing	0-3 hours	1-3 hours	3-5 hours	5-8+ hours	No restriction
Overhead Reaching	0-3 hours	1-3 hours	3-5 hours	5-8+ hours	No restriction
Sitting	0-3 hours	1-3 hours	3-5 hours	5-8+ hours	No restriction
Standing	0-3 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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