

Bluefield State College Medical Verification Leave Form

Department of Human Resources
Bluefield State College
219 Rock Street
Bluefield, WV 24701
Phone: (304) 327-4013 Fax: (304) 327-4321

EMPLOYEE TO COMPLETE

Last Name:	First Name:	Middle Initial:
Social Security Number:		Home Phone:
Home Address:		
City:		State: Zip:
Department:		Leave Due to Worker's Comp? Yes <input type="checkbox"/> No <input type="checkbox"/>
Classified Mercer Job Title/NC Title/Faculty Title:		
Supervisor's Name:		Campus Phone:

I hereby authorize Bluefield State College 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. BSC will request additional information if needed. I am aware that BSC seeks medical information in order to assess employability options including accommodation or restrictions from work. Sick or annual leave charged will be determined based upon information provided. Leave determination include Family Medical Leave Act, Parental Leave Act, ADA monitoring, use of sick leave and Catastrophic leave.

Employee Signature

Date

*** If you are seeking leave under the Family Medical Leave Act for a family member, please complete the Family Member Medical Leave Verification form that can be obtained in Human Resources.**

FOR OFFICE USE ONLY

Medical LOA Approved Through

Catastrophic Approved Through

Approved By

Date

PHYSICIAN TO COMPLETE

Patient's Name:	
Diagnosis:	
Maternity-Date and Method of Delivery:	Date of Appointment:
Prognosis:	

Indicate number of visits, general nature and duration of treatment and medications. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or work less than the employee's normal work schedule.

Please provide the following information related to this injury/illness. This will assist us in returning our employee to work.

- Is released to return to normal work duties with **no restrictions** at this time. If, so skip to 5.
- Is released to return to work with the following **restrictions** :
Hours/Day: 7.5 hours 4 hours other _____
Days/Week: 5 days 4 days 3 days other _____
Lifting: 50 + lbs. 50 lbs. 20 lbs. 10 lbs other _____
Other limitations: stooping bending overhead reaching walking
 sitting standing other _____

If other limitations, please specify:

Length of restrictions: May resume regular duties on _____ (Date) **OR** will be re-evaluated on _____ (Date)

- Is totally incapacitated at this time: Anticipated duration From: _____ To: _____
- These limitations are: **Permanent** **Temporary**
- I hereby certify that the above information is true and correct and that it is my responsibility to give objective medical information. Bluefield State College 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

Name of Physician (please print)

Physician's Phone

Bluefield State College
 Immediate Family Member
 Medical Verification /Catastrophic Leave Form

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EMPLOYEE TO COMPLETE

Employee Name:	Title:
Employee Social Security Number:	
Employee Address:	
Home Phone:	Department Phone Number:
Employee Supervisor:	Department:
Relation of Patient to Employee:	Are Alternate Care Arrangements Available: Yes <input type="checkbox"/> No <input type="checkbox"/>

PHYSICIAN TO COMPLETE

I certify that _____ has been under my professional care for
 (Patient's Name)

(Diagnosis) _____ ICD9 Code _____

Is patient seriously ill? Yes No

If yes, please indicate expected duration of serious condition: From: _____ To: _____

Treatment Plan:

Physician's Name: _____

Address: _____

Phone Number: _____

 Physician's Signature

 Date