Bluefield State University
Medical Leave Verification Form
For Employee's Medical Condition

Please return completed form to:
Office of Human Resources
Bluefield State University
219 Rock Street
Bluefield, WV 24701
Phone: (304) 327-4013 Fax: (304) 327-4321

EMPLOYEE TO COMPLETE

Note: This form is to be completed for the Employee's own medical condition. If an employee is seeking medical leave to care for an immediate family member per BSU BOG Policy No. HR-704 *Employee Leave*, please complete the Medical Leave Verification Form For Immediate Family Member, available on the Human Resources website at https://bluefieldstate.edu/resources/human-resources/forms.

Employee Name:	Job Title:	
Employee BANNER ID Number:	Home Phone:	
Home Address:		
City:	State:	Zip:
Department:	Leave Due to Worker's Comp? Yes ☐ No ☐	
Supervisor's Name:	Supervisor's Campus Phone:	

I hereby authorize Bluefield State University to obtain any medical documentation necessary to process this request. I understand the following: this form needs to be completed in full, including medical leave verification as evidenced by the attending physician; additional medical information may be required; BSU will request additional information if needed; sick or annual leave charged will be determined based upon information provided. I am aware that BSU seeks medical information in order to assess employability options including accommodation or restrictions from work. Leave determination includes Family Medical Leave Act, Parental Leave Act, ADA monitoring, use of sick leave and Catastrophic leave.

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Employee Signature Date

FOR BSU OFFICE USE ONLY

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Medical LOA Approved Through

____
Approved By Date

PHYSICIAN TO COMPLETE

Patient's Name:	
Diagnosis:	
Maternity Delivery Date (if applicable):	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. ______________________________

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

1. ☐ Employee is released to return to normal work duties with **no restrictions** on ____________ (date). If so, skip to signature section below. **OR**
2. ☐ Employee is totally incapacitated at this time: From: ____________ To: ____________ **OR**
3. ☐ Employee is released to return to work with the following **restrictions :**

These restrictions are: ☐ **Permanent** ☐ **Temporary** If temporary, restrictions end ____________ (date).

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 ______________________

Please provide any additional information: ______________________

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Employee may return to work and resume regular work duties on ____________ (date); **OR** employee will be re-evaluated on ____________ (date).

I hereby certify that the above information is true and correct and that it is my responsibility to give objective medical information. Bluefield State 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

______________________ Name of Physician (please print)

______________________ Physician's Phone

Physician's Office Name and Mailing Address: ______________________

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