SOUTHERN WEST VIRGINIA COMMUNITY AND TECHNICAL COLLEGE

Number: SCP-2484.B
Effective: September 01, 2000

TREATING LICENSED PHYSICIAN STATEMENT
MEDICAL LEAVE VERIFICATION

1. To Be Completed By The Employee:

Employee Name: _____ **Title:** _____

Upon presentation of the original or a photocopy of this signed authorization, I authorize any physician, medical professional, hospital, or other medical care institution, insurance support organization, pharmacy, governmental agency, insurance company group policyholder, employer or benefit plan administrator to provide the above-named employer, or its agent, information concerning evaluation, advice, care, treatment, or supplies provided to me, including information relating to mental illness, use of drugs or use of alcohol. I understand that such information will be used by Southern or its authorized representative for the purpose of evaluating my claim for benefits and that I or any authorized representative will receive a copy of this authorization upon request. I understand that the duration of the authorization is for six (6) months from the date shown below.

_____
Employee Signature Date

To Be Completed By The Employee If Requesting Family Leave

When family leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule of care if leave is to be taken intermittently or on a reduced leave schedule. The employee shall also state to what extent, if any, the employee will be engaged in other employment during the period of FMLA leave, and the schedule of any such employment. (Attach additional pages if necessary)

_____

_____

_____

2. To Be Completed By The Physician:

The following information is sought in connection with the above-named employee's request for leave under Southern WV Community and Technical College's Medical Leave of Absence Policy and/or the Family and Medical Leave Act of 1993.

1. Patient's name: _____

2. If other than employee, what is the relationship of the patient to the employee? _____

3. If the patient is over age 18 and is the son or daughter of the employee, does the patient have a physical or mental disability that limits the patient's ability to perform any of the activities of daily life?

   ☐ Yes ☐ No

   If yes, please specify the disability: _____

4. Diagnosis: _____

   _____

5. Is the condition a chronic condition or disability that is incurable?

   ☐ Yes ☐ No

6. Date the patient became incapacitated from work, school, or daily activities: _____

7. **Anticipated date the patient will be able to return to work:** _____
OR
Actual date the patient was able to return to work: _____

8. If the condition has not resulted in incapacity for more than three calendar days, would the condition result in incapacity for more than three calendar days if left untreated?

☐ Yes ☐ No

9. Did this condition result in in-patient hospitalization (i.e., an overnight stay)? ☐ Yes ☐ No

10. Regime of treatment prescribed. *(Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treament if it was or is medically necessary for the patient to be off work on an intermittent basis or to work less than the patient's normal work schedule of hours per day or days per week).*

A. By physician or practitioner: _____

_____

_____

_____

_____

B. By another provider of health services, if referred by physician or practitioner: _____

_____

_____

_____

INSTRUCTIONS:

If the certification relates to care for the employee, answer questions 11, 12, and 13.

If the certification relates to care for the employee's seriously ill family member, skip questions 12 and 13 and proceed to items 14 through 17.

11. If the condition is one which makes it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule, and there is no specific prescribed regime of treatment, state the aspects of the condition that make intermittent or reduced schedule leave "medically necessary." Indicate the reduction of hours per day or per week that is medically necessary, if applicable, and whether a particular schedule (e.g., off Tuesday) is medically necessary. If leave was or is intermittent, indicate the medical necessity for intermittent leave.

_____

_____

12. Is the employee unable to perform work of any kind because of a serious health condition?

☐ Yes ☐ No ☐ Don't Know

13. Is the employee unable to perform the essential functions of the employee's position because of the serious health condition? *(To determine the essential functions of the employee's position, review a statement from the employer of the essential functions of the employee's position or, if none is provided, after discussing the job with the employee).*

☐ Yes ☐ No ☐ Don't Know

A. What essential function(s) cannot be performed because of the serious health condition? _____

_____

B. Are there any accommodations that would enable the employee to perform these functions without posing a significant risk of injury to the employee or others? _____

_____

INSTRUCTIONS:

For certification relating to care for the employee's seriously ill family member, complete questions 14 through 17 as they apply to the family member.

14. Does or will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

☐ Yes ☐ No ☐ Don't Know

15. Is the employee's presence necessary or would it be beneficial for the care of the patient? *(This may include psychological comfort).*

☐ Yes ☐ No ☐ Don't Know

If unknown, what additional information would you need? _____

_____

16. Estimate the period of time care is needed or the employee's presence would be beneficial: _____

_____

17. Is it medically necessary for the employee to take leave on an intermittent or reduced schedule?

☐ Yes ☐ No ☐ Don't Know

_____
Signature of Treating Licensed Physician

_____
Printed Name

_____
Address

_____
Telephone Number

SCP 2484.B Treating Licensed Physician Statement Med Leave Verification.wpd