GLENVILLE STATE COLLEGE MEDICAL VERIFICATION FORM

EMPLOYEE TO COMPLETE

Employee Name:_____ **Date of Birth:**_____

Home Address:_____

City:_____ **State:**_____ **Zip:**_____ **Home Phone No:**_____

Job Title:_____ **Department:**_____

Supervisor:_____

RELEASE OF INFORMATION: I hereby authorize Glenville State College to obtain any medical documentation necessary to process this request. ***My treatment provider(s) may release information to Glenville State College.*** I understand that this form needs to be completed in full and additional medical information may be required. Leave determinations and requests include Family Medical Leave Act, Parental Leave Act, ADA, medical leave of absence without pay, use of sick leave and Catastrophic Leave. ***Glenville State College may request additional information from either me or my treatment provider if needed.*** I am aware that Glenville State College may also seek medical information from me or my treatment provider(s) in order to assess employability options including accommodation or restriction from work. Sick or annual leave charged or any other approved leave will be determined based upon information provided. I understand that Glenville State College will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether the accommodation(s) can be met in a reasonable fashion. A copy of this document may be accepted as the same as an original.

_____ _____

Employee Signature Date

PHYSICIAN 1 TO COMPLETE

Diagnosis or ICD-9 Code:

_____

_____

_____

Prognosis:
(Include whether this illness or injury will permanently prevent the employee from returning to work)

_____

_____

_____

This is to certify that the above mentioned patient has been under my professional care. I support his/her absence from work starting on _____ through and including _____

Please turn in, email, or fax to:
Tegan McEntire, Director of Human Resources
Fax: 304-462-6198 Email: Tegan.McEntire@glenville.edu

May return to work on _____ with no restrictions.

OR

May return to work on _____ with restrictions explained more fully on the Glenville State College Return to Work Verification form.

OR

Will be reevaluated on _____

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

Print Treatment Provider's
Name/Certification (D.O. M.D., etc.): _____

Address: _____
City/State/Zip: _____

Phone Number: _____ Fax Number: _____

_____
Treatment Provider's Signature Date

_____
Physician's Signature Date

_____
Print Name of Physician

PHYSICIAN 2 TO COMPLETE

(If applicable)

Diagnosis or ICD-9 Code:

_____

_____

_____

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Fax: 304-462-6198 Email: Tegan.McEntire@glenville.edu

Prognosis:
(Include whether this illness or injury will permanently prevent the employee from returning to work)

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Print Treatment Provider's
Name/Certification (D.O. M.D., etc.): _____

Address: _____
City/State/Zip: _____

Phone Number: _____ Fax Number: _____

_____
Treatment Provider's Signature Date

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