GLENVILLE STATE UNIVERSITY 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 University to obtain any medical documentation necessary to process this request. ***My treatment provider(s) may release information to Glenville State University.*** 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 University may request additional information from either me or my treatment provider if needed.*** I am aware that Glenville State University 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 University 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 University 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 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.

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:

Prognosis:

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(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 _____.

May return to work on _____ with no restrictions.

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

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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 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.

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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