Bluefield State College
Medical Leave Verification Form
For Immediate Family Member of BSC Employee

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

EMPLOYEE TO COMPLETE

Employee Name:	Job Title:
Employee BANNER ID Number:	
Employee Address:	
Home Phone:	Department:
Employee Supervisor:	Department Phone Number:
Relation of Patient to Employee:	Are Alternate Care Arrangements Available? Yes ☐ No ☐

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

____
Employee Signature Date

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 (Please Print): ______________________________

Physician's Office (Name, Address, and Phone): ______________________________

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______________________________ ______________________________
Physician's Signature Date

HR 06/25/14