

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

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

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 BSC 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 <input type="checkbox"/> No <input type="checkbox"/>	
Supervisor's Name:	Supervisor's Campus Phone:	

I hereby authorize Bluefield State College 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; BSC will request additional information if needed; sick or annual leave charged will be determined based upon information provided. I am aware that BSC 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.

Employee Signature

Date

FOR BSC OFFICE USE ONLY

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. _____

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: _____

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 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.

Physician's Signature

Date

Name of Physician (please print)

Physician's Phone

Physician's Office Name and Mailing Address:
