

Bluefield State University Medical Leave Verification Form For Immediate Family Member of BSU Employee

Please return completed form to:
Office of Human Resources, Bluefield State University
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 <input type="checkbox"/> No <input type="checkbox"/>

I hereby authorize Bluefield State University 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; BSU 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):

Physician's Signature

Date