



STATE OF WEST VIRGINIA
PHYSICIAN'S/PRACTITIONER'S STATEMENT

Form with sections: PATIENT'S NAME: EXAM DATE: PATIENT WAS: (checkboxes for Under my professional care, Hospitalized) DATES OF TREATMENT: PERIOD OF INCAPACITY (required): (checkboxes for NO, YES) EMPLOYEE LIMITATIONS/RESTRICTIONS (skip if patient was a family member of the employee): PHYSICIAN/PRACTITIONER INFORMATION: (NAME OF PRACTICE, TELEPHONE, TYPE OF PRACTICE/MEDICAL SPECIALITY, ADDRESS, SIGNATURE)

NOTE: When requesting a medical leave of absence without pay under the Division of Personnel's Administrative Rule, W. VA. CODE R. § 143-1-1 et seq., and/or leave with or without pay under the federal Family and Medical Leave or State Parental Leave Acts, certification forms DOP-L5 or DOP-L6, as applicable, may be required if additional information is needed.