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

PATIENT'S NAME:	**EXAM DATE:**

PATIENT WAS: ❑ Under my professional care FROM _____ TO _____

❑ Hospitalized FROM _____ TO _____

Dates of treatment: _____

PERIOD OF INCAPACITY (required): FROM _____ TO _____

❑ NO ❑ YES During this time, will or did the patient need care?

If yes, explain the care needed by the patient and why such care is/was medically necessary. Use reverse side if needed.

_____

_____

_____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EMPLOYEE LIMITATIONS/RESTRICTIONS (skip if patient was a family member of the employee):

Patient was or may be able to resume full duty employment, with no restrictions in work activities, on:

Date: _____

❑ NO ❑ YES If unable to presently return to full duty employment, can the patient return to less than full duty?

If yes, what is the period of partial incapacity? FROM _____ TO _____

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment, or any accommodation the employee requires to perform his/her job. Use reverse side if needed.

_____

_____

_____

❑ NO ❑ YES Will this condition permanently prevent the employee from performing his/her duties?

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.