

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

PATIENT'S NAME:	EXAM DATE:
PATIENT WAS: <input type="checkbox"/> Under my professional care FROM _____ TO _____ <input type="checkbox"/> Hospitalized FROM _____ TO _____	
PERIOD OF INCAPACITY: FROM _____ TO _____ (required) During this time, will or did the patient need care? No _____ Yes.	
If so, explain the care needed by the patient and why such care is/was medically necessary: _____ _____ _____	
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 <i>(Skip if patient was a family member of the employee):</i> Patient was or may be able to resume full duty employment, with no restrictions in work activities, on _____. If unable to presently return to full duty employment, can the patient return to less than full duty? <input type="checkbox"/> YES <input type="checkbox"/> NO 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 if necessary. Will this condition permanently prevent the employee from performing his/her duties? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/PRACTITIONER INFORMATION: NAME: _____ TELEPHONE: _____ ADDRESS: _____ SIGNATURE: _____	

NOTE: This form is to be used in situations which require a Physician's/Practitioner's Statement except 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. When requesting leave under these Acts, use Certification forms DOP-L5 through DOP-L8, as applicable. This form may, however, be used for a release to return to work and/or to comply with leave restriction requirements under such leave.