

# MISSISSIPPI UNIVERSITY FOR WOMEN

## Employee's Medical Certification Statement

### PLEASE TYPE OR PRINT

Employee Name: \_\_\_\_\_

#### **Section 1: Medical Condition (If medical condition is Pregnancy, skip to Section 2.)**

Date Condition Began: \_\_\_\_\_

Probable Duration of Condition  
and/or Return to Work Date: \_\_\_\_\_

Diagnosis, Qualifying Condition or Medical Facts Regarding the Condition:

Explanation of extent to which employee is unable to perform the functions of their job:

#### **Section 2: Pregnancy**

Expected Delivery Date: \_\_\_\_\_ *Note: If patient has pregnancy-related complications (prenatal and/or postnatal), it may be necessary to complete Section 1.*

Name of Practice: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Treated by: \_\_\_\_\_ *(Please Print Name)*

Provider's Signature: \_\_\_\_\_

#### **Medical Release**

*I authorize the release of any information necessary to process the above request.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Form may be faxed to: 662-241-7616  
OR mailed to:  
MUW Office of Human Resources  
1100 College Street, MUW-1609  
Columbus, MS 39701-5800