# MISSISSIPPI UNIVERSITY FOR WOMEN
## Employee's Medical Certification Statement

**PLEASE TYPE OR PRINT**

Employee Name: _____

**Section 1: Medical Condition (If medical condition is Pregnancy related, 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/Childbirth**

| |
|---|
| Expected Delivery Date: _____ |
| Estimated Recovery Time: _____ |
| *Note: If patient has pregnancy-related complications/medical condition (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: _____

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***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