MISSISSIPPI UNIVERSITY FOR WOMEN
Medical Certification Statement for Employee's Family Member

PLEASE TYPE OR PRINT

Employee Name: _____

Family Member Name: _____ Relationship to Emp: _____

Medical Condition

Date Condition Began: _____
Probable Duration of Condition: _____
Diagnosis, Qualifying Condition or Medical Facts Regarding the Condition:
Estimate the period of time the employee is needed to care for the patient:
Yes ☐ No ☐ Is inpatient hospitalization of the family member (patient) required?
☐ ☐ Is the employee's presence necessary or beneficial for the care of the patient (this may include psychological comfort)?

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