MISSISSIPPI UNIVERSITY FOR WOMEN
Employee's Medical Certification Statement

PLEASE TYPE OR PRINT

Name of Employee: _____

Date Condition Began: _____

Probable Duration of Condition: _____

Qualifying Condition or Medical Facts Regarding the Condition: _____

_____

_____

Explanation of extent to which employee is unable to perform the functions of his or her job:

_____

_____

_____

_____

Physician's Name: _____

Type of Practice: _____

Physician's Signature*: _____ Date: _____

Office Phone: _____

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

In order to use medical leave, State law requires this form be signed by a Physician. For this purpose, state law defines physician as "a doctor of medicine, osteopath, dental medicine, podiatry or chiropractic."