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

PLEASE TYPE OR PRINT

Name of Employee: ______________________________

Name of Ill Family Member: ______________________________

Relationship to Employee: ______________________________

Date Condition Began: ______________________________

Probable Duration of Condition: ______________________________

Qualifying Condition or Medical Facts Regarding the Condition: ______________________________

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Yes	No	
☐	☐	Is inpatient hospitalization of the family member (patient) required?
☐	☐	Is the employee's presence necessary or would it be beneficial for the care of the patient (this may include psychological comfort)?

Estimate the period of time care is needed or the employee's presence would be beneficial:

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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: ______________

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."

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