MISSISSIPPI UNIVERSITY FOR WOMEN
Employee's Medical Certification Statement

PLEASE TYPE OR PRINT

Employee Name: _____

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:

_____

_____

_____

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