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: _____

Diagnosis, Qualifying Condition or Medical Facts Regarding the Condition:

_____

_____

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

_____

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)?

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