STATE OF WEST VIRGINIA

PHYSICIAN'S/PRACTITIONER'S STATEMENT
for
ORGAN DONATION/PRE-OPERATIVE TESTING

PATIENT'S NAME:	**EXAM DATE:**

PATIENT WAS: ❑ Under my professional care FROM _____ TO _____

❑ Hospitalized FROM _____ TO _____

PERIOD OF INCAPACITY (required): FROM _____ TO _____

ABSENCE DUE TO (check all that apply):

❑ Pre-operative Testing ❑ Adult Kidney Donation ❑ Adult Liver Portion Donation ❑ Adult Bone Marrow Donation

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EMPLOYEE LIMITATIONS/RESTRICTIONS:

Patient was or may be able to resume full duty employment, with no restrictions in work activities, on:

Date: _____

❑ NO ❑ YES If unable to presently return to full duty employment, can the patient return to less than full duty?

If yes, what is the period of partial incapacity? FROM _____ TO _____

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment, or any accommodation the employee requires to perform his/her job. Use reverse side if needed.

_____

_____

_____

❑ NO ❑ YES Will this condition permanently prevent the employee from performing his/her duties?

PHYSICIAN/PRACTITIONER INFORMATION:

NAME OF PRACTICE: TELEPHONE:

TYPE OF PRACTICE/MEDICAL SPECIALITY:

ADDRESS:

SIGNATURE: