



Disclaimer

This document is intended to be used as a reference and procedural guide to verifying physician/practitioner statements pursuant to the need for such a statement as authorized by the Division of Personnel's (DOP) *Administrative Rule*, W. VA. Code R, §143-1-1 *et seq.* The general information this document contains should not be construed to supersede, enhance, or diminish the provisions of any federal or State law or any properly promulgated DOP rule. In the case of any inconsistencies, the statutory and regulatory provisions shall prevail. This document is written with the understanding that the DOP is not engaged in rendering legal services. If legal advice or assistance is required, the services of an attorney should be sought. Supervisors should also refer to the policies, rules, and regulations as well as consult with the human resources office within their respective agency.

NOTE: Measures for clarification and authentication involving job-protected leaves of absence or accommodations under federal and State laws, such as the federal Family and Medical Leave Act (FMLA), both the federal and State of West Virginia Pregnant Workers Fairness Acts (PWFA), the West Virginia Parental Leave Act (PLA), and the Americans With Disabilities Act (ADA), must be coordinated and executed in compliance with both federal and State regulations. For more information, please visit the DOP's website for the DOP *Reference Guide to Federal Family and Medical Leave Act and Parental Leave Acts*, and the DOP *Family and Medical Leave Act/Parental Leave Act* policy (DOP-P23). Additional guidance on the federal statutes may be found on the U.S. Department of Labor's and U.S. Equal Employment Opportunity Commission's websites. If it is necessary to initiate the interactive process under the provisions of the ADA, please visit the U.S. Equal Employment Opportunity Commission's *Enforcement Guidance on Reasonable Accommodation and Undue Hardship*. Additional information on the interactive process can be found on the Job Accommodation Network (JAN) website and by contacting the West Virginia Office of Equal Opportunity.

For technical assistance concerning specific situations, employees and employers may contact the DOP's Employee Relations Section at (304) 414-1853.

In accordance with the DOP *Administrative Rule*, W. VA. Code R, §143-1-1 *et seq.*, employees requesting sick leave or annual leave upon exhaustion of sick leave, for themselves, a family member, or a combination thereof, for more than three (3) consecutive scheduled work days or scheduled shifts must, immediately upon his or her return to work, provide a DOP prescribed physician/practitioner statement from the health care provider establishing the legitimacy of the need for and duration of the employee's absence.

The physician/practitioner statement must be complete, providing sufficient information to verify the medical necessity for leave. If an employee submits a complete and sufficient statement signed by their healthcare provider, the employer may not request additional information from the provider. However, if medical documentation is incomplete, insufficient, or appears to have been altered or fraudulent, the employer may contact the health care provider for clarification and authentication. The prescribed DOP physician/practitioner statement or other medical documentation is considered "incomplete" or "insufficient" if one or more of the applicable entries on the form is vague, unclear, or non-responsive.

An employee may provide the appropriate agency personnel with written authorization for the release of information from their healthcare provider regarding the date(s) of treatment and any limitations indicated on the medical documentation. However, employee authorization is not required to request the healthcare provider's clarification and authentication of information previously provided. The request should be limited to the most basic, factual inquiry, specifically, providing the health care provider with a copy of the medical documentation and simply requesting the health care provider to verify that the document was, in fact, completed and signed by that office/professional as presented.

To make contact, the employer must use a human resource professional, a leave administrator, or a management official. Under no circumstances should the employee's direct supervisor have access to the employee's medical documentation or contact the employee's health care provider. Information beyond what is required to verify the need for leave may not be solicited.

If it is determined any medical documentation has been falsified, appropriate disciplinary action should be implemented by the agency.

A sample *Medical Statement Verification Request and Authorization for the Release of Information* sample letter is provided below.

Resources

[Americans With Disabilities Act](#)

[DOP Reference Guide to Family and Medical Leave & West Virginia Parental Leave Acts](#), and [DOP Family and Medical Leave Act/Parental Leave Act Policy \(DOP-P23\)](#)

[EEOC Enforcement Guidance on Reasonable Accommodation and Undue Hardship](#)

[Job Accommodation Network \(JAN\)](#)

[Pregnant Workers Fairness Act \(PWFA\)](#)

[U.S. Department of Labor, Family and Medical Leave Act \(FMLA\)](#),

[U.S. Equal Employment Opportunity Commission](#)

[West Virginia Office of Equal Opportunity](#)

SAMPLE - Medical Statement Verification Request (Employer)

Note: An employee may provide the appropriate agency personnel with written authorization for the release of information from their healthcare provider regarding the date(s) of treatment and limitations indicated on the medical documentation. However, employee authorization is not required to request the healthcare provider's clarification and authentication of information previously provided.

[Date]

[Office]
[Health care provider]
[Address]

Dear Dr. [name]:

On [date], [employee name], an employee of [agency/office], provided the [enclosed or attached] physician/practitioner statement to [me or name and title] indicating [he/she] was seen [in your office or via telehealth] by [you or another health care provider such as a PA/nurse].

The purpose of this letter is to request verification of the physician/practitioner statement provided by [Ms./Mr. last name] including the date of treatment and any resultant limitations as indicated on the completed documentation.

[If the employee provided authorization, include the following statement] Please find the enclosed release signed by [employee name], which authorizes you to provide verification of the information provided in the physician's statement, including the date(s) of treatment and any resultant limitations.

To preserve confidentiality, please reply to me directly at [fax/email] or ensure that your response is sealed in the enclosed self-addressed, postage-paid envelope. If you have any questions or require additional information, please contact me at [telephone number].

Sincerely,

[Authorized Signature]
[Printed name, Job title]

Enclosures: [Enclose the physician's statement, a copy of the release form signed by the employee, and a self-addressed, postage-paid envelope, if applicable]

Sample Authorization for the Release of Information (Employee)

I, **[employee name]**, hereby authorize **[health care provider]**, to furnish written confirmation to my employer, **[employer name & title]**, regarding the date(s) of treatment and limitations indicated on the physician statement dated **[date]**.

I understand that I may revoke this authorization at any time by sending a written statement to **[employer name and address]**. This authorization was provided as indicated by my signature below. The statement must include the date on which this authorization is no longer in force. I understand that if I revoke this authorization, my employer may still use and disclose information for which action has already been taken in reliance on this authorization.

Employee Printed Name

Signature

Date

Agency Representative

Date

[The original form must be signed and retained by the employer with a photocopy forwarded to the physician.]