Guide to Verifying Physician/Practitioner Statement (DOP-L3) or Medical Documentation

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 and consult with the human resources office within their respective agencies.

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 (DOP-L3) from a health care provider establishing the legitimacy of the need for and duration of the employee's absence.

The Physician/Practitioner Statement must be complete and provide sufficient information to verify the medical necessity of the 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. The DOP-prescribed Physician/Practitioner Statement is considered "incomplete" or "insufficient" if one or more of the applicable entries on the form are vague, unclear, or non-responsive.

The employer does not need the employee's authorization to authenticate any medical documentation or to seek clarification on previously submitted information. If medical documentation appears incomplete, insufficient, altered, or falsified, the employer may contact the health-care provider to verify its authenticity or clarify the information provided. If it is determined that an employee has submitted altered or falsified medical documentation, the agency will implement appropriate disciplinary action in accordance with established policies and procedures.

Alternatively, an employee may provide the appropriate agency personnel with written authorization for the release of information to obtain additional information from their healthcare provider regarding the date(s) of treatment and any limitations indicated on the medical documentation.

Any request to the health care provider 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 resources 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.

Special Provisions for Job-Protected Leave

Measures for requesting additional information related to job-protected leaves of absence or workplace accommodations under federal and State laws, such as the federal Family and Medical Leave Act (FMLA), both the federal and West Virginia Pregnant Workers Fairness Acts (PWFA), the Providing Urgent Maternal Protections for Nursing Mothers Act (PUMP Act) under the Fair Labor Standards Act, the West Virginia Parental Leave Act (PLA), and the Americans With Disabilities Act (ADA), must be coordinated and executed in compliance with all applicable federal and State regulations.

Incomplete or insufficient information returned by an employee on job-protected leave requires the employer to advise the employee of the statement's deficiencies and provide the employee seven (7) days to have his or her provider "cure" the statement, providing sufficient information to establish the need and period for leave. If the previously submitted documentation appears altered or falsified, the employer may contact the health care provider directly to verify authenticity or clarify the information without obtaining the employee's permission.

When an employee's request involves limitations or restrictions related to pregnancy, childbirth, or related medical conditions, the federal and State PWFA require the employer to engage in an interactive process to identify reasonable accommodations unless doing so would impose an undue hardship. Requests for accommodation under the PWFA may require only the documentation necessary to confirm the existence of a limitation and the need for accommodation; employers should avoid requesting medical details beyond what is needed to evaluate the accommodation.

Similarly, when an employee's request indicates a potential disability under the ADA, the employer must initiate the interactive process to determine effective reasonable accommodations. Documentation sought under the ADA must be narrowly tailored to understanding the functional limitations and should not duplicate information already provided for FMLA or other leave statutes. Employers must ensure that requests for clarification or additional information comply with ADA standards regarding confidentiality, necessity, and scope.

When an employee's situation implicates more than one applicable statute, such as FMLA, PWFA, PUMP, PLA, or the ADA, the employer must evaluate the request under each law and apply the provisions that best meet the employee's documented needs. When overlapping protections exist, the employer should administer the leave or workplace accommodation in the manner most favorable to the employee, provided that doing so remains consistent with federal and State requirements. This approach ensures that employees receive the fullest benefit available under the law while maintaining compliance with all regulatory obligations. When an employer has sufficient information to determine that an employee's condition qualifies for FMLA, and the employee meets the eligibility requirements under the Act, the employer must designate the leave as FMLA-protected and run it concurrently with any other applicable leave benefit in accordance with FMLA regulations.

For more information, please visit the DOP's website for the DOP *Reference Guide to the 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 is available on the Job Accommodation Network (JAN) website.

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

Relevant Laws, Rules, and Policies

Americans With Disabilities Act (ADA)
DOP Family and Medical Leave Act/Parental Leave Act Policy (DOP-P23)
Pregnant Workers Fairness Act (PWFA)
Providing Urgent Maternal Protections for Nursing Mothers (PUMP) Act - Employer Responsibilities

Compliance Resources

U.S Department of Labor Family and Medical Leave Act (FMLA), FMLA Employers' Guide
DOP Reference Guide to Family and Medical Leave & West Virginia Parental Leave Acts
FMLA/PLA Frequently Asked Questions
EEOC Enforcement Guidance on Reasonable Accommodation and Undue Hardship
Employers' Practical Guide to Reasonable Accommodation Under ADA
ADA National Network ADA Web Search Portal
A to Z List of Disabilities and Accommodations
Job Accommodation Network (JAN)
U.S. Department of Labor Compliance Assistance Toolkits
U.S. Equal Employment Opportunity Commission (EEOC) Compliance Manuals
EEOC Pregnant Workers Fairness Act
U.S. Department of Labor/FLSA/Wage and Hour Division - PUMP Act

DOP State Agency Leave Administration Training

Untangling the Web of State Leaves with the federal Family and Medical Leave Act - *CourseMill DOP006-1 This course is intended to be used as an introduction to the integration of the federal Family and Medical Leave Act, WV Parental Leave Act, and Leave of Absence Without Pay as provided in the WV DOP's Administrative Rule (143CSR1). HR professionals and leave coordinators involved in employee eligibility determinations and medical leave management are highly encouraged to enroll. The course is approximately 1-2 hours and includes downloadable resources and reference material for future use.*

SAMPLE - Medical Statement Verification Request (Employer)

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

[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 request for information is to cure the original statement's deficiencies, please include the following statement and employee-provided authorization] Please find the enclosed Authorization for the Release of Medical Information 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 estimated length of incapacity or date for re-evaluation and any devices, equipment, or accommodations which may be required to enable **[employee name]** to perform the functions of **[his or her]** position.

To preserve confidentiality, please reply to me directly at **[fax or secure 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
Employee Authorization for the Release of Medical Information

Employee authorization is <u>not required</u> to request the healthcare provider's clarification and authentication of previously provided information.

[Date]

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 any limitations or restrictions on my ability to perform the functions of my position, an estimated length of incapacity or date for re-evaluation and any devices, equipment, or accommodations I require to enable me to perform these functions.

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 ceases to be 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 provided to the physician.*]