# STATE OF WEST VIRGINIA
# PHYSICIAN'S/PRACTITIONER'S STATEMENT

**PATIENT'S NAME:** 

**EXAM DATE:**

**PATIENT WAS:**

❑ **Under my professional care** **From:** ____________ **To:** ____________

❑ **Hospitalized** **From:** ____________ **To:** ____________

**PERIOD OF INCAPACITY:**

**From Date:** ____________ **To Date:** ____________

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

If unable to presently return to full duty employment, can the patient return to less than full duty?

❑ **YES** **If YES, what is the period of partial incapacity?**

❑ **NO** **From** ____________ **To** ____________

**LIMITATIONS AND RESTRICTIONS:**
Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment or any accommodations the employee requires to perform his/her job.

Will this disability prevent the employee from performing his/her duties?

❑ **YES** ❑ **NO**

**PHYSICIAN / PRACTITIONER INFORMATION:**

**NAME:** **PHONE**:

**ADDRESS:**

**SIGNATURE:**

**Note:** This form is to be used in all situations which require a Physician's/Practitioner's Statement (DOP-L3) except when requesting a leave with or without pay under the State Parental Leave or federal Family/Medical Leave Acts. When requesting leave under these Acts, use the Physician's/Practitioner's Certification (DOP-L4).