STATE OF TENNESSEE
EMPLOYEE SICK LEAVE BANK
SECOND FLOOR, JAMES K. POLK BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0635
TEL. (615) 741-5431 1-800-221-SEIL (7345)
FAX (615) 532-3209

SICK LEAVE BANK MEDICAL CERTIFICATION

COMPLETED FORM MUST BE MAILED OR FAXED BY THE MEDICAL OFFICE DIRECTLY TO THE SICK LEAVE BANK AT THE ADDRESS ABOVE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Sick Leave Bank to make all necessary investigations concerning this application. I further authorize the release of any records or information, including but not limited to medical, Workers' Compensation, State Retirement, or Social Security disability that is sought in connection with this application.

Patient's Name and Birth Date (Please Print) **Patient's Signature (or legal representative)**

Name of Medical Doctor/Surgeon (Please Print): _____

Part I: Initial Form: Part I and Part II (Entire Form) completed by the medical doctor/surgeon only.

1. HISTORY (Please answer all questions.)
   (a) Date of first visit for this condition? ..... Mo. _____ Day _____ Yr. _____
   (b) When did symptoms first appear or accident happen? ..... Mo. _____ Day _____ Yr. _____
   (c) Is this a work related injury or illness with the state? ..... Yes _____ No _____
   (d) Is this a work or service connected injury or illness with another employer? ..... Yes _____ No _____
   If yes, name, address, and telephone number of the non-state employer. _____
   _____
   (e) Was the patient referred to you by another medical doctor/surgeon? ..... Yes _____ No _____
   If yes, list the referring medical doctor/surgeon's name and telephone number. _____
   _____
2. PRESENT CONDITION (Please answer all questions.)
   (a) Is the **present condition** the same or a similar condition or a condition related to, resulting from, or recurring from a **previously diagnosed condition**? ..... Yes _____ No _____
   If yes, please check the appropriate box(es) and provide previous condition/diagnosis and dates.
   Same Condition: ___ Similar Condition: ___ Related to: ___ Resulting from: ___ Recurring from: ___
   Describe previous condition/diagnosis and list date(s): _____
   _____
   (b) For the **present condition**, was the patient: **Hospitalized**? ..... Yes _____ No _____
   I**f yes**, please **list hospitalization dates**. _____
   (c) For the **present condition**, did the patient have surgery? ..... Yes _____ No _____
   If yes, please **list surgery dates**. _____

REQUIRED: Patient's Name and Birth Date (Please print): _____

Part II: For follow-up visits: Part II may be completed by the medical doctor/surgeon or nurse practitioner/physician's assistant.

COMPLETED FORM MUST BE MAILED (ADDRESS ON PAGE 1) OR FAXED TO 615-532-3209 BY THE MEDICAL OFFICE DIRECTLY TO THE SICK LEAVE BANK.

3. DIAGNOSIS - Current medical condition(s) preventing employee from performing the duties of his/her job. **(Be specific – Please provide the ICD–9 code(s) and a written description.)**:

   Primary diagnosis: _____ (ICD-9) _____ (Description)

   Secondary diagnosis: _____ (ICD-9) _____ (Description)

4. TREATMENT (Please describe the treatment.): _____

   _____

5. APPOINTMENT INFORMATION: (Current Condition - May include office visit, date of surgery, or hospital visit)

   (a) Date of visit for this completed form:..... Mo. _____ Day _____ Yr. _____

   (b) Date of next visit:..... Mo. _____ Day _____ Yr. _____

6. EXTENT OF DISABILITY FOR PATIENT'S REGULAR OCCUPATION:

   (a) Is the patient temporarily medically unable to perform any duties of his/her job?..... Yes _____ No _____

   If yes, beginning date: _____ ending date: _____

   (b) When will the patient medically be able to return to work **with** restrictions?
   Approximate Date: _____ Indefinite: _____ Never: _____

   (c) When will the patient medically be able to return to work **without** restrictions?
   Approximate Date: _____ Indefinite: _____ Never: _____

   (d) What is the usual recovery period for this condition? _____

   (e) Did the patient require additional recovery time due to complications for this condition? Yes _____ No _____

   If yes, please explain: _____

The first Medical Certification form (initial form for this condition) requires the signature of the medical doctor/surgeon. Forms based on follow-up visits require the signature of the medical doctor/surgeon or a nurse practitioner/physician's assistant.

I hereby certify that the above information is true and correct and that the information provided is objective medical information relative to this patient's application to the Sick Leave Bank.

PLEASE PRINT:

Name: _____ (**Medical Doctor/Surgeon Name and Title**) _____ (**Signature and Title**)

Address: _____

Address: _____ _____ (**Date**)

Telephone #: (_____)_____

Fax #: (_____)_____