TN Department of Human Resources

(615) 741-5431 FAX (615) 532-3209
EMAIL: SLB.SICKBANK@TN.GOV

SICK LEAVE BANK MEDICAL CERTIFICATION

COMPLETED FORM MUST BE FAXED OR EMAILED FROM THE MEDICAL OFFICE DIRECTLY TO THE SICK LEAVE BANK AT THE FAX NUMBER ABOVE

Employee Name (please print)_____

For employee? (circle one) YES NO For employee's minor child? YES NO

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. I further authorize the Sick Leave Bank to share this information with my agency's leave administrator(s) in order to make a determination of eligibility for any other type of protected leave.

_____ _____

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

Name of Medical Provider (Please Print): _____

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** related to, resulting from, or recurring from a **previously diagnosed condition**? ..... Yes _____ No _____
   Describe previous condition/diagnosis and list date(s): _____
   _____
   (b) For the **present condition**, was the patient: **Hospitalized**? ..... Yes _____ No _____
   If **yes**, please **list hospitalization dates**. _____
   (c) For the **present condition**, did the patient have surgery? ..... Yes _____ No _____
   If yes, please **list surgery dates**. _____
   Was the surgery **medically necessary**? _____

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

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3. DIAGNOSIS - Current medical condition(s) preventing employee from performing the duties of his/her job. **(Be specific – Please provide the ICD–10 code(s) and a written description.)**:

Primary diagnosis: _____ _____
ICD-10 Description

Secondary diagnosis: _____ _____
ICD-10 Description

4. 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. _____

5. INFORMATION FOR CARE OF **MINOR CHILD**:

Briefly describe the care the parent will need to provide for the minor child:_____

Due to the condition of the minor child, will it will be necessary for the employee to be absent from work?

If yes, beginning date:_____ ending date:_____

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: _____

This Medical Certification form requires the signature of one of the following types of healthcare providers:
A Doctor of Medicine or osteopathy, podiatrist, dentist, clinical psychologist, optometrist, or chiropractor (with limitations), nurse practitioner, nurse-midwife, clinical social worker, or physician assistant authorized to practice within the scope of his/her practice, and/or,
any healthcare provider from whom the employer or the employer's group health insurance benefits manager will accept a medical certification to substantiate a claim for benefits.

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:

_____ _____ _____
Medical Provider and Title **Signature and Title** **Date**

Address: _____

Address: _____

Telephone #: (_____)_____

Fax #: (_____) _____

STATE OF TENNESSEE
EMPLOYEE SICK LEAVE BANK
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NASHVILLE, TENNESSEE 37243-0635