Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

PHYSICIAN CERTIFICATION FORM

Pursuant to T.C.A. § 50-6-242 (a)(2)(B)
This form is only to be used for injuries occurring on/after July 1, 2014.

Patient Name: _____ DOB _____

State File # _____ Date of Injury _____ Date of MMI _____

I, the undersigned, hereby certify that due to permanent restrictions on activity the employee has suffered as a result of the injury the above-named employee no longer has the ability to perform the employee's pre-injury occupation.

_____

Physician Printed Name Physician Signature Date

_____

Medical License Number Issuing State